Mental health nursing attitudes towards patient involvement in risk assessment as part of recovery focussed care.

A thesis submitted for the degree of Masters by Research

By
Claire Danskin

School of Applied Sciences,
Abertay University.

February, 2020

Declaration

Candidate's declarations:

I, Claire Danskin, hereby certify that this thesis submitted in partial fulfilment of the requirements for the award of Masters by Research (MbR), Mental Health and Counselling, Abertay University, is wholly my own work unless otherwise referenced or acknowledged. This work has not been submitted for any other qualification at any other academic institution.

Signed [candidate's signature]…  …….

Date……25/02/2020……..

Supervisor's declaration:

I, [insert Principal Supervisors name] hereby certify that the candidate has fulfilled the conditions of the Resolution and Regulations appropriate for the degree of Master by Research in Mental Health and Counselling in Abertay University and that the candidate is qualified to submit this thesis in application for that degree.

Signed [Principal Supervisor's signature]… …  ……...

Date……25/02/2020……..

Certificate of Approval

I certify that this is a true and accurate version of the thesis approved by the examiners, and that all relevant ordinance regulations have been fulfilled.

Supervisor……..…….

Date……

Abstract

Background In a recovery focussed mental health service the aim is for patients to be involved in all aspects of their care (Scottish Government, 2012). Within mental health care, risk is incorporated in policy and procedures guiding Mental Health nurses' practice. Earlier studies have shown that while mental health nurses felt strongly in support of risk assessment, many were strongly resistant to patients being involved in completing risk assessments. There is little evidence to suggest why this resistance exists, whether mental health nurses feel risk assessing is detrimental to therapeutic interactions or a barrier to recovery focussed care (Downes et al., 2016).

Aims The aim of this project is to explore mental health nurses' attitudes to risk assessment and how that affects recovery focussed care.

Methods This research was conducted as a mixed method project involving three individual studies to give an overall picture and triangulate evidence to cover the aims of the research. Study one was completed by the collation of quantitative data. The data was taken at a single time point from all current nursing documentation in three under 65 acute psychiatric wards within an NHS health board. This served to survey frequency of risk assessment completion and involvement of service users within the process. The study also looked at whether the risk assessment documentation was revisited within the suggested time frames. The information was collated in a simple table format to affirm completion and service-user involvement, and to give context to the subsequent research studies.

Studies two and three were completed using a qualitative design to draw out the experiences and views of the registered nurses (study two) and patients (study three) on the wards. Invitations were sent to all current registered nurses and all current acute inpatients regardless of gender, diagnosis or length of service/admission. All participants were adults aged 18 to 65. All patients were deemed to have capacity to participate by their designated psychiatric consultant. Data were then gathered by individual single round semi-structured interviews. All data was transcribed verbatim from audio recordings and a thematic analysis was carried out by the research team. After care was available for anyone who potentially identified any additional needs following the interviews

Findings Study one showed that patients are frequently not actively being involved in the risk assessment process with 30% of patients having no risk assessment paperwork completed. Of those completed, 66% indicated that there was no patient involvement in the assessment process, 72% were not completed on time and 83% had not been reviewed since completion. Initial interviews with nursing staff identified that possible reasons for this include lack of time, avoidance of difficult conversations, and a lack of perceived value to the documentation. Interviews with service-users showed a strong wish to be involved in the risk assessment and the care pathway, however the study also indicated that patients had limited awareness that there were risk assessment documents completed regarding their care. The results also showed that patients feel they are not listened to and that they benefit more from their peers on the ward than they do from interactions with nursing staff.

Conclusion

Many papers written on risk assessment claim that by being involved in the process the patient experiences a range of outcomes including feeling listened to (Sweeney et al 2014), developing trust for the nurse (Downes et al 2014) and gaining sympathetic support (Department of Health 2007). Most papers such as the work of Hseoi and colleagues (2015), Deuter and colleagues

(2013) and Neech and colleagues (2018) take a more negative approach to the risk assessment process and look at the detriments of risk assessing in more detail than they do the overall benefits with particular attention payed to the difficulties in completing the documentation. This study has highlighted that the nursing staff themselves may be a contributing factor to the recovery focus of risk assessment on the mental health wards due to avoidance of difficult conversations, fear of aggression or lack of value to the process of risk assessing.
There needs to be a cultural shift around viewing risk assessment as a negative conversation to a recognition of the individual's strengths. Risk assessment should no longer be a tool that is viewed as invaluable and restrictive and should be taken forward as a collaborative tool that embraces all aspects of the individual's experiences as a means of planning future care to allow the individual to move forward.

Recommendations

Drawing on the findings of the three studies that took place the project drew three key recommendations.

1. As mental health drivers remove the center of care from in-patient services and place a greater emphasis on community based care it is highlighted that there is a need for the documentation used in care to change to accommodate and strength the change of emphasis. It is recommended that further research take place to streamline the paperwork used in Mental Health nursing into a continuous care record that follows the patient seamlessly through their journey.
2. It was highlighted that there was a lack of training and arguably this lack of understanding could contribute to the lack of value placed on the risk assessment documentation. It is recommended that the NHS trust in the study incorporates more robust training around risk assessment and risk management.
3. It was identified by both nursing staff and patients that there is a lack of collaborative working within the inpatient ward in the studied trust. It is recommended that research into collaborative working between the nurse and the patient is carried out with a view to making nursing documentation person centered and less objective.

Table of Contents

1. Introduction

The role of the mental health nurse on the acute psychiatric inpatient wards is documented widely with shifts in cultures and practice over the decades. Most significantly and unarguably the biggest movement has been away from the care provided in asylum type settings to encompassing and empowering the patient on every step of their journey. This recovery style of mental health nursing whilst not a new phenomenon is very much changing the way in which mental health nursing is developing. As a result, patient involvement in all decisions made around their care is at the centre of all UK nursing policies, practice and procedures (HM Gov 2011, Happel 2014, Lester at al 2014, Meiklebust et al 2018, Jorgensen et al 2018).

By involving the patient in their care and the subsequent decisions made around the direction their care takes the nurse forms a collaborative partnership between the nurse and the patient (Hall et al 2013, Lim et al 2017). Recovery focussed care works on the premise that mental health professionals acknowledge the diverse, complex and individualism of the lived experiences of the patient rather than treating the signs and symptoms of mental illness alone (Happel 2014, Peitman 2018). This approach particularly highlights and recognises the strengths and abilities the patient has to manage their own behaviours, their self-determination and responsibility for their actions all of which are pertinent in the assessing and management of risk (Coffey et al 2017, Lim 2017). Seeing the person as an individual rather than how they present builds for a therapeutic interaction and a relationship embedded with hope and trust (Happel 2014).

Mental health nurses are undoubtably in a unique position where they can empower the patient, break down stigma and empower people to adapt their lives successfully utilising what they value most in terms of their individual strengths, family support and mental health services (Hseoi et al, 2015). Recent research has, however, shown that mental health professionals show less optimistic attitudes towards the progress of treatment for people with a mental illness than their colleagues in the medical sector (Schulz,2007). This is further enhanced by the work of Bjorman and colleagues (2008) who concentrated their work on mental health professional attitudes and found that nurses in acute psychiatric wards generally had more positive attitudes

then their mental health colleagues that work in the community or inpatient rehabilitation wards. This appears to have changed significantly by the completion of Hsiao and colleagues' study in 2015 where their findings were that the acute mental health nurses were found to be the most negative group of mental health clinicians. Hsiao (2015) hypothesised that this may be due to a more task orientated practice of care which restricts the amount of time acute nurses have in direct contact with their patient group. This could be the case in the nursing staff attitudes towards risk assessing where research in 2011 by Gilbert and colleagues highlighted that where there was a lack of quality completion of risk assessment documentation, it was not due to a lack of commitment by the nurses. Gilbert found that the mental health nurses that worked on inpatient wards had the most positive attitudes towards risk assessment. The work of Hawley et al in 2010 who's research had similar findings reporting that mental health nurses on acute inpatient wards were more likely to use positive risk and empower the individual with responsibility for their own actions.

The research findings of both Gilbert (2011) and Hawley (2010) identified that there is a great deal of variability in the number of details collected, completion rates and nurses approaches to risk assessment stating a possible lack of understanding of the 'dynamic' nature of risk.

The completion of risk assessment documentation is required to take place for every patient under the care of mental health services throughout the UK as recognised by the Department of Health (2007) and Mental Welfare Commission in the Mental health Act (2015). It is not a task that can be set aside or ignored and is one of the highest profile tasks of mental health care professionals in today's climate (Woods 2012). As indicated by the work of Downes (2016), Szmukler (2013) and the recommendations of the department of health (2007) the completion of risk assessment forms in practice is considered essential, but there are recognised barriers to its use such as the relationship between the nurse and patient (Bowland and Bremner 2013) and nurses understanding of the risk assessment process (Downes, 2016). There are also questions around its effectiveness with Szmukler (2013) suggesting that there is no evidence to support the necessity of risk assessing at all in mental health. Maguire and colleagues (2018) doubt the value of risk assessment paperwork on the basis of the lack of up-to-date information recorded and the fluidity of risk in a mental health setting. It appears that no recent published studies have been carried out to audit practice in the use of risk assessment according to guidance.

Downes and colleagues (2016) in their findings record that the nurses they recruited felt strongly against the involvement of patients in the completion of risk assessment paperwork. They stated that this was due to a belief that the therapeutic relationship will be damaged by the interaction. This is contradicted in research where it has been shown that many patients are dissatisfied with their care, feeling that inpatient admission is non-therapeutic due to the poor relationship between staff and themselves. In their study regarding patient satisfaction Sweeney and colleagues (2014) found that patients formed better therapeutic alliances with staff members who appeared interested in them and engaged them in interactions in a professional manner. By having such an interaction, the patients interviewed by Sweeney and colleagues (2014) stated that they felt understood which indicates that whilst Downes' study (2016) identified the nurses fears of risk assessing as a barrier to the therapeutic relationship their beliefs may be mis-informed. This study aims to examine this disparity, looking at the perspectives of nurses towards patient involvement in risk assessment.

The current risk assessment tool 'Working with Risk', which is used with in the selected trust is based on a third-generation style of risk assessment which incorporates both clinical judgement and the use of actuarial risk assessment guidance. This in theory allows the clinician a more flexible approach to measuring risk using the maximum amount of information available to them, drawing on the views of a multi-disciplinary team and the views, opinions and experiences of the patient themselves as well as their family and carer. Using this approach, it is documented that risk assessing will therefore be a dynamic and transparent process that is fluid in nature along the care pathway of the patients (Deuter et al 2013, Woods 2012). Systematic reviews by Meiklebust and colleagues (2018) when exploring mental health nurses' attitudes to documentation revealed that nursing documentation in care in general is inaccurate and inadequate when reviewed in line with recovery focussed care. When completed correctly, Kettle and Woods (2009) argue that the process will allow the patient to feel confident that they are involved in their care and that there will be a safe, caring and appropriate care journey towards recovery. Rimandi and colleagues (2011) carried out a mixed method research study involving over 96 participants to look specifically at patient empowerment in risk management in the mental health setting. They highlight in their findings and discussions the benefits of patient involvement in the risk management process for the mental health patient stating that working collaboratively patient safety is improved. They highlight that the patient is the "expert" in their

care and there should be a shift from the protective risk assessment process to allow for a more collaborative approach.

Research has shown that during the completion of documentation the participation and the 'voices' of the patients are 'marginalised' (Jorgensen et al 2018). This is further highlighted when exploring the use of the recovery model in the concept of risk, an area studied by Perkins and Repper (2016) and Hill and colleagues (2012) who describe the two aspects as 'incompatible', drawing the emphasis that recovery focussed care builds on the personal strengths of the patient allowing them to take back control of their life and developing skills to deal with the challenges the patient faces. Both Hill (2103) and Perkins and Repper (2016) compare this to risk assessment and management which takes on a more negative focus around problems and allows the nurses as professionals to take control of the situation removing any potential risky behaviours and with it any opportunity to build coping skills to face future challenges in life.

Throughout health care, but more significantly in mental health, there have been recent changes to policy on the back of a requirement that patient participation takes place. This has given patients a new role as decision making individuals in their own care pathway. Mental health nurses along with all health professionals are now expected to promote this involvement of their patient group regardless of diagnosis or insight. That said this involvement allows for the expectation that the patient takes ownership of their care pathway (Jorgensen et al 2018, Lester at al 2006, Meiklebust et al 2018).

1.1 What is Risk?

Throughout literature there appears to be no definite definition of the word 'risk' compounding that it is multi-dimensional and that it holds a different meaning to individuals depending on their area of speciality, environment and systems. Risk must be viewed as contextual in that it differs depending on the profession, environment and organisation, for example, risk of suicide in an inpatient setting is different to risk of suicide for a patient being treated in the community due to the level of observation carried out. A patient in the community may only be visited by their community nurse once a week for an hour leaving their mood and mental wellbeing unmonitored for considerable lengths of time whereby the patient in the inpatient setting has continuous

interactions with the nursing team, their mood is monitored and assessed continuously and help and support are on hand to react to any sudden changes in mental state. The lack of a clear definition to the meaning of risk is a view supported by both Crowe and Carlyle (2003) and Deter and colleagues (2013) in their review of the meaning of risk. Both stating that there is scarcity of literature providing a critical analysis of the concept of risk and poor definition of what risk means.

In terms of mental health practice, risk is defined as a potential negative outcome or behaviour arising from the actions of patients who use mental health services. This has reference to two identified areas namely risk to self in terms of self-harm, suicide or neglect and risk to or from others in terms of violence and aggression and physical or psychological harm (Baker et al 2013, Coffey et al 2016, Hill et al 2013).

It has become a pertinent and central part of today's mental health service that risk assessment takes place (Hill et al 2013, Higgins et al 2016). It is no longer possible to be a mental health professional without assessing, measuring and managing risk and at times it can take priority over diagnosis/treatment and can come before the individual and their needs (Brown and Calnan 2012). According to Tummey (2008) the concept of risk has displaced care when defining the significance of patient interactions, creating a more negative narrative around the implications of behaviour. This displacement of care is also highlighted in the works of Brown and Calnan (2013) who point out that a need to manage risk tends to result in a more controlling, restrictive care environment that manages the risk of a minority of patients and results in the care needs of other patients being over shadowed. To illustrate this, take the simplistic example of practice in acute mental health wards today of removing sharp objects such as razors from all in-patients when admitted. This practice is to reduce the ‘risk’ of self-harming by patients. It may be the case that only a small minority of patients would use such implements to self -harm however all patients are restricted from access to such items even though to many their personal appearances can at times be highly valued. This practice is not monitored on an individual basis but as an NHS wide practice. We are of the opinion that removing all risk from the mental health inpatient setting produces a clinical area that is a false environment to that which the patients will live in the community and therefore the assessment of risk could be argued to be invaluable or unmeasured when looking at discharge.

Brown and Calnan (2013) also highlight more specific concerns around the interactions that take place when discussing risk, these concerns are supportive of the earlier arguments of Tummey (2008). Both articles highlight that due to the popular belief that those with a mental health diagnosis are risky in their behaviours and that mental illness brings with it violence or aggression, those that are in need of mental health care are less likely to seek help due to fear of been treated in a risk averse culture. They argue that risk controlling practices present as barriers to the meeting of needs.

Derkson and colleagues in their study in 2011 highlight the effects of caring for mental health patients on the mental health nurse. Due to the extreme behaviours and emotions of the mental health patient group, Derkson argues that the nurse can experience extreme burn out and experience severe emotional stress including anger, pity and fear. These emotional stresses of the mental health nurse in themselves affect the therapeutic relationship, collaborative working and communication of information between the nurse and patient.

1.2 Risk Assessment

An integral part of mental health services is acute inpatient psychiatric care, in this field the measure of risk, its management and patient involvement is widely debated (Baker et al 2013, Coffey et al 2016, Stenhouse 2013). Within the healthcare system the purpose of the acute inpatient ward is to provide ‘support and treatment’ to those who are viewed as too much of a 'risk' to remain in the community. Stenhouse (2013) defines this differently replacing the more widely used term of risk with 'dangerousness' as the main reason for admission. The term dangerousness raises alarm in communities and stigmatization of those with mental illness however it is a term which appears in research and nursing documentation continuously, despite the implications this has on the individuals requiring care. Hewitt (2008) highlights that the use of the term dangerousness has led to a belief that those with mental health illness are inevitably violent or aggressive and that it fails to take into consideration that dangerousness cannot be observed and is not an objective phenomenon as a result of clinical pathology. It could be argued that this terminology alone impacts on the patient and preconceived perceptions of patients by mental health nurses throughout care. This is further compounded in the need for a

standardised risk assessment to be completed non admission where nursing staff are asked to measure how severe the risks of danger are to build care plans around any identified risks. Accepting the above definition that risk is a potential negative outcome or behaviour as a result of an action by a person who uses mental health services, it is the process of assessing that risk in an acute inpatient setting that is the basis of this study.
The Department for Health (2007) define risk assessment and management as the active and systematic process in which potential and actual risk is not only identified but evaluated, managed and monitored. Risk assessing in the context of this paper is the process of assessing the safety of the patient as well as the risk that any individual poses to or from others. The risk assessment should draw on the strengths of the individual, recognise their resilience and include the individual's recollection of significant events (NHS Quality Improvement 2005).

The management of risk is a pragmatic necessity in the light of mental health crisis, the evaluation of risk occurs in the context of a 'risk averse culture within health care and can counter act the aspirations of the therapeutic ambitions of a service' (Downes 2016). The negativity around the terms used within the care setting compounds itself in the delivery of risk assessments that take place.

1.3 Risk assessing and the acute mental health ward

Attitudes towards care and risk have developed vastly over recent decades. In 1806 Katherine Allen and her husband changed the approach of mental health nursing against a background of asylums and guard-like keepers that locked away those with mental illness. Heading the retreat in York they developed an approach that built firmly on relationships. Such nurse-patient relationships were grounded by respect, dignity and tolerance. Care was personalised and based on benevolence. The focus even at that early developmental stage was around building self-esteem and restoring self-control (Brown et al 2012). If we are to believe the views of Szmukler (2013) that by risk assessing, mental health practices are indeed attempting to control patients and staff, then it could be justifiably argued that indeed care has gone full circle and that the use of such tools as paper restraints is bringing back the era of segregation and custodial like hospitalisation.

In today's mental health system admission to an acute psychiatric admission ward is deemed necessary by the patients care team. A Consultant Psychiatrist will have deemed the patient too unwell to have their care safely managed in the community. The decision to admit is not made easily and is a last resort to a less restrictive measure such as treatment in the community. All admissions to an acute inpatient ward are governed by the Mental Welfare Commission who rule that any restrictions on a person's freedom should be done with the 'minimum restriction necessary in the circumstances' (Franks 2005). This means that on arrival on the acute ward the patient may be experiencing a range of mental health symptoms that could result in heightened arousal, psychotic symptoms or/and a frightened state, all of which are indicators of increased risk. Risk is also increased due to previous trauma, personality traits, co-occurring alcohol or drug problems or neurodevelopment disorders (Lim 2017).

Whilst this list is extensive in the range of symptoms and heightened responses possible it highlights the importance of risk assessing with the patient at the earliest possible time after admission, acknowledging their vulnerabilities and strengths to ensure therapeutic recovery focussed care. In response to this, there is a wide consensus that mental health nurses must use an informed and collaborate approach to risk assessing. The Mental Welfare Commission emphasise this in their ten overriding principles of the Mental Health Act (Franks, 2005), stating clearly that they expect all mental health providers to 'take account of the patients past and present wishes', 'make sure (the patient) gets all the support and information needed to take part in decision making' and that 'the views of the carer, named person or guardian are considered'. This is echoed by the Nursing and Midwifery Council (2018) who govern the roles and responsibilities of registered mental nurses and state in section two of the code of conduct that all registered nurses should respect and listen to the patient as an individual, including them in all aspects of their care.

Embedded in current policy is the aim that the patient will be involved in all aspects of their care, this is referred to as a recovery focussed care model in today's mental health service (Scottish Government 2012, NHS Quality Improvement 2005, NHS Quality Improvement 2009). This involvement includes all elements of care planning, interactions, risk assessment and risk management (Deuter et al 2013, Coffey et al 2016). Contemporary approaches to care require that the care provided is a recovery based, person centred, fluid and transparent process that should move with the patient throughout their therapeutic journey (Stenhouse 2013; NHS Quality

Improvement 2005 and 2009). It is within this care setting that risks, perceived or actual, must be monitored and evaluated effectively in order to provide the best therapeutic environment for the person. This should be carried out while optimising the prevention of harm to self and others (Stenhouse 2013).

1.4 Is risk assessment beneficial?

Whilst there is agreement that risk assessment, as for all nursing care, should be evidence based (Department of Health 2007) there are problems with what the 'evidence' around risk assessing is (Szmukler et al 2011). This is a view supported by Wong and colleagues (2012) who found no professional policy around risk assessment and a limited evidence base for use in the training of mental health professionals in assessing risk. This is despite the Department of Health (2007) recommending that staff undertake training around risk assessing a minimum of every three years. Despite a set of guidelines and best practice being in place, a review of the available literature and bibliography of current best practice guidelines reveals only further additional guidelines cited which appear to have been reworded and drawn together to form new updated versions of the guidelines set. When attempting to identify the under-pinning evidence base for the risk assessing procedure used in the selected NHS trust the research team were unable to source any research-based evidence to support the procedure of risk assessing. Szmukler (2013) also carried out research, alongside a literature review, into the evidenced base of risk assessing and highlighted that there is 'no available evidence' that indicates the necessity of risk assessing in mental health care. This point is highly relevant to this research when discussing the attitudes of nursing staff to the risk assessing process and the interaction that takes place in that there appears to be no actual benefit of the written risk assessment taking place for both patient and nursing staff other than a paper trail for use as evidence and audit purposes by the organisation. When considering the many factors of a risk assessment and if we are to accept there is an importance to the acknowledging of risk in mental health, some would suggest that risk assessment is not in the best interest of the patient and is used and seen as an attempt by the Health Care organisations to control the behaviour of patients and staff (Szmukler 2013). Szmukler's (2013) paper argues that risk assessment tools have become a form of accountability through guidelines and protocols meaning risk assessing has become a new

means of governing those working as mental health professionals. This argument takes away from the value of the risk assessment as a clinical tool and instead accepts the tool as having little value other than for bureaucratic use if things go wrong and as a means of attributing blame (Szmukler 2013). Downes and colleagues (2016) balance this argument stating that despite the lack of evidence base, nurses continue to view risk assessment as a core role of their practice and not as a part of clinical governance or organisational obligations.

In their article exploring the development of clinical risk management Bowland and Bremner (2013) express the view that the emphasis on risk assessment and management has a direct impact on the therapeutic relationship between nurse and patient and claim that if nurses are portrayed as focussing on these past behaviours it could be detrimental to any psychosocial interventions. This, again, is in direct conflict with the recovery focussed work that places the patient as an individual at the centre of their own care. This element of care planning is essential in line with the Nursing and Midwifery council (2018) and current mental health policy (Deuter et al 2013, Neech et al 2013 and NHS Quality Improvement 2005 & 2009,).

Szmukler and colleagues (2011) state that risk assessment has placed a demand on mental health nurses that is ‘impossible’ to meet when asked to predict who of their patients will be ‘dangerous’ to others. In his later research, Szmukler (2013) suggests that given that mental health nurses now appear to work in a culture that is risk adverse, they must think about the extent to which they are prepared to allow their professional practice to be redirected by the risk approach. In practice this means that nurses may need to take a more objective approach and utilise their expertise and clinical judgement beyond the information in the risk assessment document, considering the presentation of the patient, the circumstances which are taking place and the support mechanisms that are available. If nursing practice becomes dictated by documentation, then the person-centered and recovery focused element of care is removed.

Current risk assessment tools vary widely among mental health service providers both nationally and internationally (Department of Health, 2002). Critics argue that there is little evidence to show the ability of such tools in accurately measuring the possibility of risk (Boland and Bremner 2013; Wand 2012). Hawley (2010) adds to this argument by highlighting the validity of risk assessment documentations due to the wide variability in both their design and their measurement of risk. An example of this would be the historical use of the RA1 documentation in the NHS trust used in this research project. The RA1 was a simple questionnaire style

assessment tool drawing on historical documentation to give the nurse the option of a yes/no/not applicable answer. With the RA1 a more detailed assessment was only carried out should the nurse feel it was necessary at that given time. The newer *Working with Risk* documentation (Annex 7) calls for the nurse to provide a detailed response accounting the patients experience and recollection of events as well as available information for other agencies, families and those providing care. This newer, more individualised tool asks the nurse to document information around the same group of risks but drawing on the strengths of the patients as well as premorbid presentations, giving a more detailed assessment of risk. Hawley (2010) states that documentation may be important to NHS trusts due to them being the only tangible marker available to show progress towards achieving the standards of risk assessment sought by organisations. This argument that the risk assessment tool is solely used to support the organisation's ability to show that they are managing risk is damaging to the validity of the risk assessment tool itself and the significance that nursing staff may place on the document could be impaired. This is despite the Department of Health clear guidance that 'risk assessment should be structured, evidence based and as consistent as possible across settings and service providers' (2009). The Department of Health (2009) does, however, also give numerous examples of risk assessment tools that are suggested for use each recommended for specific risk elements depending on which is felt relevant. With such wide variation been suggested by leading organisations it is not surprising that there are a range of tools used by different NHS trusts with varying approaches to risk measurement and management. This is a concern also raised by Graney and colleagues in their study of suicide risk assessment published in 2020, they found that 33 of the 85 NHS trusts in the United Kingdom used risk assessment tools that were locally derived rather than a generic nationwide, evidence-based risk assessment tool. Graney and colleagues highlight a lack of consistency and effectiveness from the risk assessment that are in place and similarly question the benefit from such tools due to fluidity of risk, inconsistency of completion and poor training for staff who complete the documentation. The concerns regarding risk assessment use are not limited solely to psychiatry, McClatchey and colleagues (2019) studied the use of suicide risk assessment tools within Emergency departments in Scotland and found similar results with two thirds of clinicians using empirically and locally developed tools and one third of clinicians using their clinical judgement alone to decide if a referral to psychiatry was needed.

The tool currently used in the selected NHS trust to measure risk to self and others was implemented with the aim of being recovery focused and to meet with the National Standards of Clinical Governance and Risk Management as agreed by NHS Quality Improvement Scotland (2005).

The evidence suggests that the reality of risk assessment tools is not as idealistic as the intended aims. It is our point of view that a risk assessment tool or risk management plan is only as good as the time and effort put into its completion, communicating outcomes and updating as relevant. Where the value of patient involvement and/or the documentation itself is questionable amongst nursing teams then the value of the information documented will surely be tainted also. It is this viewpoint that led to the following studies being completed and the reasoning sought as to if patient's involvement takes place in the risk assessment process as well as the nurses' feelings and rationale behind this.

To counterbalance the negativity around risk assessing suggested by the likes of Szmuckler (2011, 2013), and to provide good clinical care the nurse must include risk assessment as well as risk management, not only to protect others from any one individual but also the individual from others (Graney et al, 2020). Those with a mental health diagnosis are just as likely to be harmed by others as they are to harm others despite public opinion formed from exposure to recent media attention towards Mental Health patients (Royal College of Psychiatrists, 2016). This bears on recent guidelines in that risk assessment should focus as equally on the strengths of the patient in order to keep them safe as well as keeping safe others (Graney et al, 2020).

There is theory amongst research that risk-assessing could become a barrier to the therapeutic relationship) between the nurse and patient (Coffey et al 2017, Downes et al,2016). It is undeniable that mental Health nursing today places a high value on person centered care (Deuter et al, 2015 and Langan, 2008). The patient should be involved in all aspects of assessment, admission, care planning and discharge, including those the nurse views as risky, with the patients views and experiences documented and agreed). This should take place as a collaborative piece of work between practitioner and patient (Langan 2008).

The move to recovery focused care, often cited as person centered care is not a new phenomenon and has gained considerable attention in nursing literature over the past decade (O'Donovan 2007). The terms recovery focused care and patient centered care are often used

interchangeably, and both refer to care that places the individual at the heart of their recovery journey (Leese et al 2014). There are many definitions of what recovery focused care is. One very apt definition in the terms of this study is given in the work of O'Donovan (2007) as 'understanding the persons outer and inner worlds from their frame of reference'. This cannot be done without the involvement of the individual. Despite the arguments around the use of risk assessment tools in predicting risk, by drawing on the identified strengths, the nurse as a clinician has a platform to display an interest in the person as an individual, showing that they respect the patient's story and experiences and are willing to take the time to listen (Graney et al 2020). A good therapeutic relationship however must include both sympathetic support and objective assessment of risk (Department of Health 2007). Correctly used the interaction that takes place around risk could be formed as the basis of many aspects of nursing practice including care, safety and discharge planning as well as the basis for future interactions. Best practice guidelines highlight that through promotion of the process of risk assessment and with a positive and open relationship between nursing staff and patients, risk management can be a positive process as well as a therapeutic tool in a patient's recovery. With such a diversity in risk assessment tools the strengths and weakness of risk assessing must be acknowledged in that any risk assessment is only valid in the current situation and therefore needs to be a fluid nursing tool (Wand 2012, Royal College of Psychiatrists 2016).

1.5 Current Guidelines

Despite risk assessments taking place, risk cannot completely be eradicated from the mental health service regardless of the risk management process that takes place (Royal College of Psychiatry 2016). NHS Quality Improvement Scotland (2009) however highlight that through effective risk management risk can be reduced to an 'acceptable level'. Similarly, they highlight that 'it is a mandatory requirement that NHS Boards have systems in place to manage risk' including risk assessment and prevention. It is a duty of all NHS boards to provide a safe environment for everyone, taking on board the views of all care givers including patient's family, patients and the multi-disciplinary team.

There are seven key points in the Best Practice Statement by NHS Quality Improvement Scotland (2009) when considering risk during the admission to adult mental health inpatient services: -

1 Risk assessment and management is integral to every stage of the admission process and should be a routine part of inpatient care.
2 Risk assessment and management should be viewed as a dynamic, ongoing process, not a single event/episode on admission.
3 Observation levels determined by risk assessment require explicit policies and procedures on reviewing observation levels.
4 Accurate risk assessment helps reduce risk of suicide or deliberate self-harm. The HEAT target from Delivering for Mental Health: (Target 2-Commitment 7) specifies reduction of suicide rate between 2002–2013 by 20%. Working towards HEAT targets is supported by the Mental Health Collaborative.
5 The Department of Health commissioned a review on the evidence of risk assessment that reflected clinical priorities. The outcome of the review clearly maintained that risk assessment tools should support rather than replace clinical judgement.
6 Ongoing risk assessment and management builds upon pre-admission risk assessment information.
7 Acknowledgement should be given to the potential benefits to a patient when a robust risk assessment and management plan is carried out and developed, especially if compiled collaboratively.

1.6 Nursing attitudes

Having considered the need for risk assessment in the mental health setting and acknowledging that risk exists due to the presentation and experiences of the psychiatric patient, there is minimal research about the attitude of Mental Health nurses to risk assessments and the potential barrier to effective assessment this represents. Downes and colleagues (2016) carried out research in this area to explore policy, practice and attitudes of nursing staff in relation to risk assessing. The work covered seven health care regions across Ireland issuing a self-completed survey to Mental Health Nurses. Downes and colleagues (2016) issued in total 1320 surveys of which they had 381 returned completed. The results showed that nurses felt strongly in support of risk assessment accepting that risk assessing is a primary part of their clinical

practice, the nurses do however also see it as the responsibility of everyone involved in patient care to ensure that the risk assessing documentation is completed. The research also indicated that a high proportion of respondents strongly disagreed with the patients being involved in completing risk assessment. Crowe and Carlye (2003) state that not including the patient in risk assessing is detrimental to safety.

Without including the patient and allowing them to disclose any thoughts which may signify risk, the nurse can only use their judgement based on observation which maintains the uncertainty of risk and distorts the element of risk that needs to be managed. Due to the identified lack of current literature, it would seem indicative that this is an area that requires further discussion and research. There is little evidence to suggest the reasoning as to why nurses feel risk assessing is detrimental to therapeutic interactions and for what reasons it is seen as a barrier to recovery focussed care (Downes et al 2016). Further research is also necessary to understand nursing approaches to risk assessment and what the patient's understanding and expectations from the risk assessment process is. It is the aim that the proposed research will address this gap in current literature.

1.7 'Working with risk' Assessment tool.

The '*Working with risk'* assessment tool currently used in the chosen trust is a structured clinical assessment documentation which utilises both actuarial and clinical approaches. These approaches draw on the use of both statistical and mathematical methods of measurement but include the advantage of utilising the nurse's clinical judgement (Connie and Murray 2007). This approach requires nurses to gain the patient history, assess their current mental state and gather any other relevant information to establish the risks of the patient. It is proven that individuals rate risk on a varying scale depending on personal views, values and experiences (Graney et al 2020). For this reason, risk assessment should not be carried out in whole by any one individual and should be part of a multi-tiered approach with the views of all parties involved in the patients care accounted for (Department of Health 2007, Graney et al 2020, Royal College of Psychiatry 2016). Research also highlights that risk assessments are only valid if the clinician has access to relevant good quality information and is competent in risk assessing, this is only possible if risk assessment is a continuous process that is transparent and flexible

(Department of Health, 2007). Higgins and Colleagues in 2016 highlight this in their discussions suggesting that there is a displacement of risk assessment as the means to formulate a safety plan and the information used. They suggest that the purpose of the risk assessment is to achieve an overall picture of the person from differing perspectives in order to safely measure the risk that is presented. There is also argument that the risk assessment process should be completed out with the profession realm and should include the family members and supports of the individual involved this not only provides important information and background situations but also a source of emotion support and protective factors for the individual (Higgins 2016). The *Working with risk* documentation is designed to be used by nursing staff and should include the patient in its completion. The document should be completed fully and given to the patient to sign to show involvement, consent to information sharing and their involvement in the care planning that has taken place because of completing this documentation. The documentation should be completed within 24 hours of admission to any psychiatric ward and reviewed again after a 72-hour period. Following this the documentation should be reviewed at least weekly or earlier if there is a significant change. The result of these reviews means that the *Working with Risk* documentation is current and indicative of the patients' presentation at any one time, this enhances its validity when transferred to further services. The documentation is part of the Health and Social Care Partnership working agreements allowing the elements of risk to be transferable across the multi-disciplinary team. When completed effectively as a live document the Working with Risk document provides the opportunity to offer patient centred and recovery focus care both of which are major drivers in today's mental health care system. From an empirical view, to be used to its full effectiveness this risk assessment requires the document to be consistently updated and fully inclusive, not only of many risk factors but of the views of the patient and those they wish to be part of their overall care planning. There have been no known studies completed specifically on the working with risk tool that the author is aware of, therefore continuation of its use would benefit from further research in this area.

2 Rational, aims and objectives of the project.

The aim of this project is to explore nurses' attitudes to risk assessment and how that affects recovery focussed care.

Higgins and colleagues (2015) highlight that to risk assess in a recovery framework there needs to be therapeutic interactions with the patient, and they should be involved in all stages of their care including those evolving from the risk assessment process. Patient involvement in care is strongly supported across care models throughout mental health nursing (NHS Quality Improvement 2009). Acknowledging the findings of Downes and colleagues (2016) that mental health nurses feel it is not appropriate to include patients in risk assessment, some exploration is needed as to whether this is a consistent finding and why it might be the case. With an insight gained into nursing staff attitudes it may be possible to make risk assessment a recovery-based process in the future. To fully meet the aims of this study and strengthen its findings in terms of development in patient involvement, it is essential that the patient perspective was also studied despite it being recognised that patient views are largely underrepresented in current research (Stewart et al 2014).

To allow the project to achieve its aim the following objectives were set; -

- To identify the level of patient involvement in the risk assessing process as recommended by current nursing models
- To address the identified gap in research and explore nurse's attitudes to patient involvement in current risk assessments.
- To explore the knowledge, views and experiences of patients around risk assessments.
- To identify if risk assessment is viewed as a barrier to recovery focussed care by nurses

3 Ethical Considerations

Agreement was initially sought from nursing management and all Consultant Psychiatrists covering the acute admissions ward after discussion of the proposed research and consideration of any advice or guidance given. Ethical approval was then granted by the NHS Research Ethics Council through the Integrated Research Application System (I.R.A.S) with further approval sought and agreed by the University of Abertay Research Ethics Council.

In Study 1 there was ethical consideration given to the use of patient data without having sought their consent. This was discussed at length by the research team with the guidance of the local and national NHS Research Councils. Since no patient information of any kind was been used and it was solely a gathering of statistical data recording the completion and compliances rates, it was deemed by the Research Councils that consent was not required for this stage of the research study.

The following two qualitative studies raised several ethical considerations primarily around data collection, interviewee distress or concerns, breaches of confidentiality, reporting of concerns following divulgence by participants, and participant withdrawal. The third study which involvement patient participation added further to this with considerations around consent from vulnerable adults and potential disclosures. In order to address the considerations around data collection all paper-based data were kept in a locked storage space that only the researcher has access to. Audio recordings were also destroyed at the end of each interaction to prevent any breaches of confidentiality.

When considering the issues around consent particularly with the patient group it was decided that agreement from the relevant Psychiatric consultants be sought. Each consultant was asked to identify any of their current patients which they felt should be excluded from being invited to participate on the grounds of capacity or if detrimental to their care pathway. Following invitations and information letters being issued all participants from both study two and three signed a consent form prior to any research being carried out.

If at any time a participant wished to withdraw from the research, they were free to do so without any consequence or detriment to themselves. It was agreed that any data collected from

that individual would be withdrawn from the study if this request came prior to submission of the work for the thesis. Patient anonymity will remain intact and full confidentiality maintained.

4 Data Protection

The Chief investigator and study staff involved with this study complied fully with data protection requirements. In order to fully protect the data computers used to collate the data had limited access measures via usernames and passwords. The research team have ensured that none of the published results contain any personal data that could allow identification of individual participants. As the research included patients and nursing staff as well as access to nursing notes the researcher currently holds a full and current disclosure Scotland certificate in line with current NHS Policy. There was no financial or any other gain for participating in the study nor was there financial cost to any individual who participated in the study. As the study consists of the participation of those employed by NHS Fife there was no cost to the individual at any times. The research findings only include the actual views and experiences of the participants involved identifying key themes and experiences.

5 Methodology

The project was carried out as a three-part mixed method study using both qualitative and quantitative data.

5.1 Quantitative data

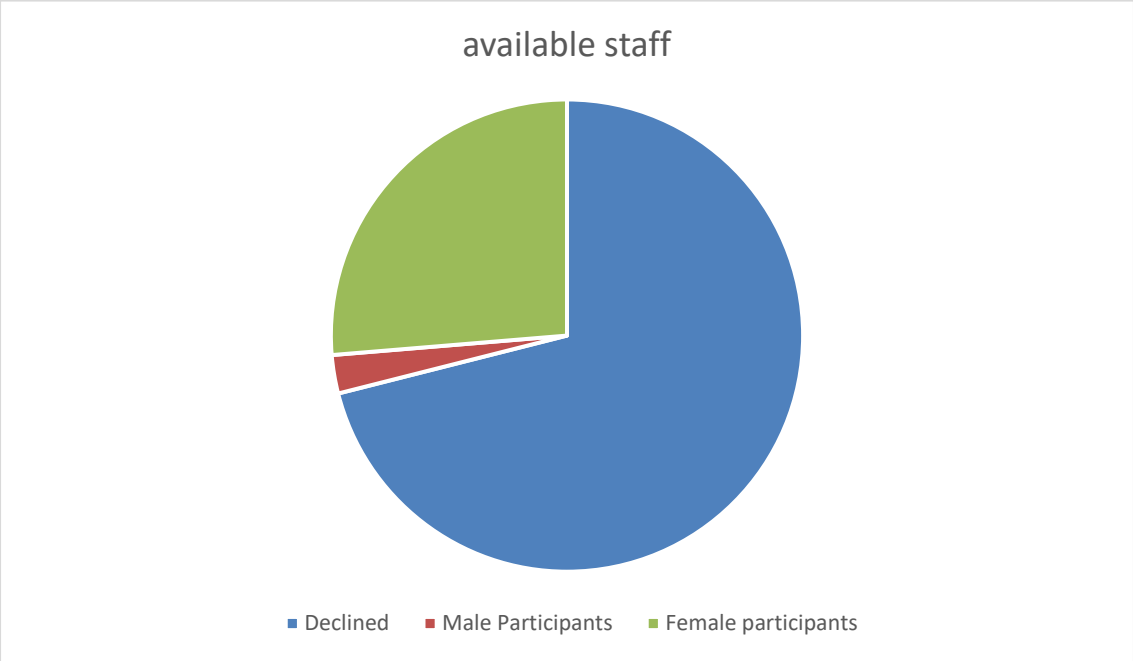
The first study in the project was completed as a quantitative research study with the aim of establishing the extent to which risk documentation is completed as per the procedures and guidance set by the selected trust and the level of patient involvement in the process of risk assessing. An analysis of existing nursing documentation for patients aged 18 to 65 on acute adult admission wards was carried out. This collation of data gave baseline information to establish the degree to which the staff in the acute admission wards of the selected trust completed risk assessments, and how frequently patients were involved in the completion. These data were captured over a 48-hour period to ensure that it was current and represented the patient population of the selected trust at a single point. The data involved a binary analysis asking if risk assessment had occurred as indicated by the presence or absence of a risk assessment document on file, whether it was complete or incomplete established by the field completion, had risk assessment occurred in the 24 hour post-admission window, had it been reviewed 72 hours later, and had risk assessment involved the patient as indicated by the presence of the patients' signature on the risk document, or by an entry on the variance section of the form that patient had been involved but refused to sign. The rationale behind this stage of research was to capture a true indication of current interactions prior to any interviews in studies 2 and 3.

5.2 Qualitative data

Studies two and three were completed using a qualitative design through interviews with nursing staff and current in-patients within the selected NHS trust. Participants were recruited by invitation and provision of information on the research including aims, methodology, terms of consent, and the right to withdraw. An invitation was sent to all nursing staff on NHS acute admissions wards in the selected trust utilising the W*orking with Risk*, risk assessment tool

(n=38). Staff who were interesting in taking part contacted the researcher by email. They were then given a further information letter and a twenty-four-hour period to consider the information before signing consent forms and interviews taking place.

All participants (n= 11; 28.94%) were registered mental health nurses with between 6 month and 21 years nursing experience. All participants were employed on one of the admissions wards within the selected NHS trust.



This study aimed to explore personal views, so a qualitative explorative approach was used as this provides a systematic, subjective approach to describe life experiences (Burns and Grove 2009). Semi-structured interviews were selected for this study to allow participants to elaborate in their answers and allow the interviewer the opportunity to elicit more information from the participant as the interview progressed. Semi-structured interviews permit scope for individuals to answer questions more on their own terms than the standardised interview permits, yet still provides a good structure for comparability over that of the focused interview. This was followed with thematic analysis, which allows for a summary of the collected data content, grouping into codes then developing themes and interpreting meaning (Braun and Clarke 2017).

The questions used in this study were

1) Can you tell me your understanding of current risk assessing processes with the working with risk tool?
2) How do you feel about the interaction that takes place when completing the initial risk assessment?
3) Who do you feel should be involved in the completion of the documentation?

These questions remained consistent throughout the interviews however due to the sequential analysis that occurred further questions were added on an individual basis in each interview as themes become more prominent.
Having already completed the pre-interview briefing and informed consent process the main body of the Interviews was scheduled to last 60 minutes with selected open-ended questions developed solely by the researcher for use in this study, with an additional 15 minutes allowed for pre-briefing and informed consent processes.
The interviews covered the participant's experiences and understanding of risk assessment, views on patient involvement in risk assessment and views on potential barriers to risk assessment. Timescales varied depending on respondents replies. All interactions were audio-recorded with permission from the participants. Interviews were carried out away from the clinical area to ensure confidentiality and minimise disruptions to the working environment. Interviews were then transcribed verbatim and a thematic analysed was carried out by the researcher to identify key themes.
The third study in the project was a replication of study two in its approach with participants recruited from the inpatient wards' current patient group. Invitation letters were initially left on each of the wards in the selected NHS trust for patients to read at will. These indicated the date and time that the researcher would attend the ward to give further information. Information letters were then given to those who expressed an interest and at least a twenty-four-hour period allowed to pass before interviews took place.
Interviews took the same format as the previous study in that there were minimal fixed questions allowing the interactions to flow and patients to expand on their answers. In order to gather data on similar topics the same set of questions as asked to the nursing staff in study two were repeated: -

1) Can you tell me your understanding of current risk assessing processes with the *Working with Risk* tool?
2) How do you feel about the interaction that takes place when completing the initial risk assessment?
3) Who do you feel should be involved in the completion of the documentation?

All interviews were recorded by Dictaphone and transcribed verbatim.
Both qualitative studies were analysed thematically. This was completed by multiple rounds of discussions amongst the research team all of whom had differing professional backgrounds including mental health nursing, psychology and counselling. This variety of profession backgrounds and experiences allowed meanings identified to be challenged by and discussed with the supervising members of the research team. This allowed for stronger theme identification to be agreed by three of the project team and could be evidenced strongly by the data collated with less individual bias or individualised translation of the data received. By using this form of analysis, it allowed for a in depth conversation that compared and contrasted the views of all involved and allowed for triangulation of findings.

5.3 Participant Criteria

The study only included those aged 18 to 65 who had been deemed to have consent to participation and are fluent in the English language. All patients were deemed to have capacity to participate unless otherwise specifically identified by their psychiatric consultant. The relevant consultants were asked via email to identify any patient that they felt would be detrimentally affected by participating in the study regardless of reason. There was no discrimination on the grounds of diagnosis or length of admission. All psychiatric consultants caring for patients on the relevant wards were asked to agree to all patients having capacity to opt into the study at the time of recruitment and those deemed not to have capacity were excluded from the study. There was only one such identified patient. It was explained fully in the information leaflet that any confidentiality will only be broken in line with current NHS guidelines if there is felt to be a disclosure which indicates significant risk to themselves or others. Participants would be made aware of any such concerns if they arose.

Seven patients (8.24%) engaged in the interviews, initially the research was carried out in the form of a focus group however this proved difficult to conduct due to clinical activity and patient willingness to be involved and further data was collated by interview. Data saturation levels were reached quickly with patient opinions and views been unanimous amongst those that volunteered and carrying out any additional interviews was not deemed to be valuable by the research team.

All interactions that took place did so with the aim of gather a view of the patient experience in involvement in their care and their views on how it impacts their care journey.

5.4 Researcher reflexivity

As a registered mental health nurse, the researcher was consistently aware of the need to reduce any potential bias throughout the project. In order to minimise such bias a great deal of self-awareness was required regarding language used, body language and questioning style. Maintaining this level of self-awareness whilst challenging at times allowed the researcher to critically engage with their interviewing practice through both individual and supervisory reflection. Reflection took place following each set of interviews to ensure that meaningful

interactions were conducted between the researcher and the participant. Reflection was also carried out throughout the analysis process of the data received in an attempt to ensure that preconceived ideas or conclusions were not included, and the analysis and data was based on the results only. This allowed all views and hypothesis to be challenged by the supervisory team and alternative meanings or interpretations introduced. Such challenges to interpretation of results allowed for development as a researcher as well as reflection of nursing practice.
There is also recognition that the researcher is employed by the NHS trust in which the research was conducted, to further eliminate any potential bias or participant influence a decision was made that the researcher would not include their direct area of work in any research that was completed. This adjustment to the study was not difficult as the acute inpatient wards are based across three hospital sites in different towns in the trust. At the time of the study no-one involved was directly employed in any of the wards studied.

6. Findings

6.1 Quantitative Findings

Audit of all available nursing documentation

Sample size	n=83
Fully completed	n=56 (67.47%)
Completed within 24 hours	n=43 (51.81%)
Reviewed within 72 hours	n=19 (22.89%)
Completed with patient	n=28 (33.73%)

All active nursing files were audited in the selected trust. In total 83 nursing notes were analysed; 56 (67.47 %) of the files had completed risk assessment documentation in place (see Appendix 2.1). This is clearly fewer than the 100% recommended as best practice. Even when allowing a variance, due to the nature of the adult acute wards and the possibility that patient movement was such that adequate time had not passed to allow for the document completion, the number of completed documents was still significantly short of a satisfactory threshold.
The guidance and best practice guidelines that are documented on the risk assessment indicate clearly that the document should be completed within 24 hrs of admission this is to allow the patient a period on the ward if necessary and to lighten the pressures on nursing staff to complete the document immediately. Despite the 24-hour framework recommended, few of the risk assessments were completed in time with only 23.21% of the risk assessments showing evidence that they had been discussed at all during the patient's admission.
It should be noted that if the documentation were not complete, but a variance was documented by nursing staff explaining the absence of any information then it would be documented in the findings that the risk assessment had been considered and therefore recorded as ‘yes’ for the purpose of completion rates. This was justified by the research team as there was clear indication that the risk assessment had been considered and the patient approached but no information was gained. There where however no such risk assessments in place.

Data were analysed using the 56 completed documents from the initial findings and eliminating the remaining 27 files that had no completed risk assessment in place (see appendix 2.2). Data also revealed that only 46.43% of the completed risk assessments had been completed with patient involvement. That is only 33.73 % of all available risk assessments on the acute inpatient's wards in the trust and further strengthens the need for an examination of the reasons for this.

6.2 Qualitative Findings

Nursing staff talked freely about the risk assessment process recognising that there is an existence of risk in mental health nursing. The nursing staff were honest in their replies that the risk assessment often does not get completed and when it does it is rarely with-in the 24-hour timeline recommended. Through the interviews key themes were identified and evident in all interviews conducted. Nurses spoke about time constraints as a primary reason for lack of completion largely due to large amounts of paperwork during the admission process and a lack of understanding and value in the working with risk documentation itself. All participants responded with at least one answer relating to the therapeutic relationship between themselves and the patient, often stating that they are empathetic towards the emotional state of the patient in that the questions could cause distress but overwhelmingly that the interaction was uncomfortable and difficult and may place the nurse in potentially adverse situation.

Participants identified the overwhelming amount of paperwork required to be completed when a patient is admitted to the wards.

"*staff can't just stop everything to complete the risk assessment on top of all the other documentation that needs completed"* (participant 2)

"*there is so much paperwork that needs doing like literally between doctors' meetings, telephone calls, admissions discharges and audits there in, so no time left"* (participant 5)

“we have tons (paperwork) needs completed just to get the patient on the system and officially on the ward that’s before we even look at the other paperwork” (Participant 6)

Frustrations were also repeatedly voiced about the duplication of information with nursing staff feeling that the risk assessment had already been covered by other mental health teams prior to admission. Staff voiced that they felt that they were documenting the views of other health care professionals or story telling from previous documentation. Nursing staff clearly recognise the value in identifying the risk but do not value or prioritise the completion of the documentation as a part of their nursing role.

“*all our assessments come from.....people who have already talked about all the risks with the patient at assessment or know them and know their history and risk. Why can't the risk assessment come on to the ward with the patient.”* (Participant 5)

“communication.... we have to send a completed risk assessment to the C.P.N (Community Psychiatric Nurse) on discharge but when they readmit the patient, they don’t send one back and we have to do it all from scratch again. It’s a live document should someone who is in the service not always have a up to date assessment anyway” (Participant 6)

When exploring the value of the paperwork nursing staff responded with comments such as *“no-one reads It, they should but they don’t"* (Participant 4)

“information is passed on through safety briefs and handovers not the risk assessment” (Participant 2)

When asked why the information is taken from other documents instead of a centralised risk assessment the reply was?
“*it's just easier*” (Participant 2)

Another registered nurse stated.

‘it’s (risk) not really a conversation that takes place if I’m honest the nurse in charge of the shift normally makes the decision” (Participant 3)

Whilst nursing staff cited time as a major contributing factor towards the completion of risk assessments it became clear from the data analysis that this was just one of many reasons that the paperwork was not completed, and several other key themes emerged from the interviews with nursing staff.

The findings of the research found that nursing staff place little importance on the actual documentation of risk assessment feeling that the actual process of risk assessing is a fluid and important process in their clinic practice.
“*you always have to be aware of any risks* " (Participant 4)

The actual documentation of such risk assessment held little value to those being interviewed unlike the actual ongoing assessment of risk itself.

“risk changes so quickly that it's easier to make judgements on the presentation at that time, it’s the nature of the job. The risk assessment gets filed away in the nursing notes and never really revisited without even realising that we are doing it. It's what mental health nursing is about” (Participant 3)

“it's hard because often it’s a spur of the moment decision, you have to think fast and normally it depends on the presentation of the person at that time as things change so fast” (Participant 3)

“You have to look at the big picture, how they are presenting that day and how much you know about the patient. You don’t normally have time to research the decision it’s a on the spot thing …. clinical judgement.” (Participant 5)

Some participants went as far as stating that it was a governing process more beneficial to the trust than it was to the patient. Staff see the process as an act of liability.

“That’s what our job is, its fighting fire, making decisions about patient care on impulse, taking the blame if things go wrong. We have to risk assess to keep ourselves safe.” (Participant 6)

It was apparent that the nurses interviewed were not shying away from the responsibility and took full ownership of the importance of being aware of and measuring the risk despite the lack of value voiced in the documentation.
“Effective risk management is the most important and crucial part of mental health nursing” (Participant 5)

The findings indicate that nurses feel discussing risk is difficult and therefore can be very emotionally driven or increase the risk of verbal or potentially physical aggression. This was cited in all interviews that took place but was often in the latter part of the conversation and was only revealed by direct questioning of the staff emotions around the risk assessment process.

“ it can be upsetting to the patient or make them angry that we are asking about their past” (Participant 3)

“well, no-one likes people being upset and if there is a risk of someone being angry towards me then I feel really uncomfortable. I mean patients get angry all the time, but it is worse when it is you asking the questions. I wouldn’t like someone asking me about my past let alone a complete stranger digging into my life” (Participant 3)

“what if something on the risk assessment is a trigger, what if they become aggressive” (Participant 4)
“by the time the patient is admitted to the ward they have probably told their story like 3 times already, they are ratty and sometimes scared or angry. I just don’t see how that can be helpful. “(Participant 6)
“Whoever admitted them will already have told us about the reasons what does bringing up past events add to the story other than upset. It’s safer not to piss them off at that stage” (Participant 6)

"Risk assessments can be intrusive, particularly regarding taboo subjects such as illicit or problematic drug use, risk to children..." (Participant 7)
"I understand why the risk assessment is completed but I don't understand why we would need to ask them about potentially bad periods in their lives when they are already in crisis" (Participant 4)
"it's just easier to talk about positive things.... I mean you don't really know the person on admission. If they have been in before then you already know the risks but if you don't know them. It like walking into the unknown a bit" (Participant 4)

These points were justified by the mental health nurses by their understanding and undertaking of the recovery focused care expected of them. This presents itself in an emphasis on helping the patient move forward with their care as opposed to concentrating on the past. This was identifiable through comments such as

"Of course, it's all negative things. we are supposed to be recovery focused" (Participant 4).

The third study showed that patients felt they were not involved in the risk assessment at all with the majority of patients not having any awareness that a risk assessment takes place to document their strengths and vulnerabilities. The patients that participated did however voice a desire to be involved feeling that they could contribute to documentation and nurses over all understanding of their needs with a valuable input.

Interviews were opened asking patients to explain their experience of involvement in their care, surprisingly all involved responded with negative comments such as "what involvement" or "I haven't been involved at all".
When asked more specifically about the admission paperwork that required to be completed, again, the research team were met with negative comments with a gained sense that patients were not experiencing a positive admission and found the process lengthy and impersonal,
*"The doctor did my bloods and stuff, ******* showed me which bed I could have then I went for a cigarette".*

“I can't remember much about it; I came in went to bed and that was it”.

When asked about their experiences with risk assessment all but one of those that took part could not recall having a risk assessment carried out or being involved in its completion. The patients were asked directly if they were aware of the risk assessment documentation being completed, those that were not aware had the documentation described to them in full to ensure an understanding. Responses were overall that patients had no understanding or awareness of the process or documentation and how it impacts their care with responses such as: -

“That never happened with me, no-one has sat down and spoke with me about anything”.

“no one has ever bothered to give me time and find out what I want out of being in here, I thought this would be all about me.”

The one participant that was aware of the risk assessment responded.

“Is that the one they say I wrote this, sign it”.

Indicating that they had seen a risk assessment tool but not being involved in its completion or understanding its purpose.

The findings identified that at the time of the study the patients were finding support from their fellow patients rather than from the staff with a community like environment clearly formed,

“it was ok the patients in here are all really nice”,

“Yeah, you learn more from the patients than the staff”.

“Staff just sit in the office”.

“It's always been like that we talk more to each other than we do to staff.”

Whilst many of the comments were more about their care in general and not specific to risk assessment, the significance cannot be ignored. Comments included: -

“I am here voluntarily, I wanted to come into hospital, I didn’t ask them to take over my life and tell me what I can and can't do?”

“Aye but seriously, I came for help and all it seems like we do is smoke and watch telly I want to go out of here feeling better, I want to be able to cope with my life.”

“it would be nice for someone to get my side of things.”

“##### (RMN) sat down with me and listened for ages today, I’ve been in hospital 3 times and that’s the first time I have had anyone listen and talk with me. It meant a lot, it's nice to know people care and will listen.”

7 Key Themes

Nursing staff talked freely about the risk assessment process recognising that there is an existence of risk in mental health nursing. The nursing staff were honest in their replies that the risk assessment often does not get completed and when it does it is rarely with-in the 24-hour timeline recommended. Through the interviews key themes were identified and evident in all interviews conducted. Nurses spoke about time constraints as a primary reason for lack of completion largely due to large amounts of paperwork during the admission process and a lack of understanding and value in the working with risk documentation itself. All participants responded with at least one answer relating to the therapeutic relationship between themselves and the patient, often stating that they are empathetic towards the emotional state of the patient in that the questions could cause distress but overwhelmingly that the interaction was uncomfortable and difficult and may place the nurse in potentially adverse situation.

7.1 Patient involvement

The nurses from study two all voiced the importance of working in collaboration with the patient and there seemed to be a sense of achievement in developing the therapeutic relationship and helping the patient in their recovery pathway. Therefore, it is not surprising that they voice their frustration at not having the time to do this. Despite voicing such a drive for collaborative working the patients are not been involved in the NHS trust selected for this study and similarly in Ireland as found in the original study by Downes et al (2016). Whilst it is recognised that the two studies were not carried out in unison or with the same methodology a conclusion could be drawn that would lead one to surmise that the problem is not limited to the areas studied. It may also indicate a much wider spread national avoidance of discussing risk with patient groups in acute mental health services.

Patient involvement is, as has already been highlighted, the cornerstone of today's mental health services (Graney et al 2019, Higgins et al 2016, Oshea 2016). The patient is seen as the ‘expert’ in their own care and the driving force in their own recovery, they are the one who has the lived experienced of the topics that need to be discussed which is superior to the academic or professional opinions of the mental health nurse (Higgins et al 2016). This applies in almost

all areas of their care including risk assessing. Risk assessment requires a full historical recollection of not only the events, but the emotions involved, the predisposing and precipitating factors. Without this expertise the nurse can never gain a full understanding of the level of risk that exists (Tambuyzer et al, 2014).

Such discussion around the level of patient involvement in their care has several supporting arguments, the main been that it is the right and ethical thing to do (Tambuyzer et al 2014). This argument considers the human rights of the individual respecting the views and wishes of the individual their families and carers. This argument has grown in support vastly over recent years as individual human rights and approaches towards respecting diversity and individualism have grown with advocacy groups more recently striving for a greater 'voice' and promoting the right of equality for mental health patients as a marginal group (Tambuyzer and Van Audenhove, 2013, Lester et al 2006).

Risk assessing has a direct impact on the care given and received by a person, it can lead to limitations on freedom and influences multi-disciplinary team decisions. In recognising the consequences of the risk assessment documentation, it should also be considered that when used correctly it is a fluid tool that follows the patient throughout their care journey which for many could be life duration. It is therefore important that the documentation also draws on the strengths of the person including coping skills and self-management abilities to avoid risky situations (Higgins et al 2016). These skills and strengths should be shared as greatly as the negative aspect of risk, promoting the ability of the individual to have insight into recognising when a situation may become difficult or pose a risk to themselves or others.

The second argument voiced in literature about patient involvement is the enhancement of the care received from mental health care providers when working collaboratively. Providing more individualised care and listening to the patient as an individual rather than taking a more paternalistic approach of deciding for the patient is beneficial to both parties. Involvement allows an environment in which empowerment is allowed as a personal progression for the patient.

The patients that participated in study three were largely unaware that the risk assessment documentation existed but perhaps more significantly voiced unanimously that they had a desire to be involved in all aspects of their care planning. Patients want to be listened to, they want to be able to tell their story and at certain points in their journey want to be open about their emotions and experiences. Patients will automatically look to the nursing staff to provide this

platform (Lester et al 2006). Study two however seems to indicate that the nurses avoid these conversations in fear of causing distress or being faced with a threatening situation. The findings of the studies suggest that nursing staff are not yet achieving the patient centred interactions that Mental health care policy is striving to achieve.

7.2 Nurses' avoidance

Communicating at a care planning level builds relationship, allows engagement and allows the empowerment of the individual (Hall et al 2013, Neech 2018). However, the findings of the research carried out shows that mental health nurses within the chosen trust are failing to display this level of communication in the area of risk assessing. Given the expectations of the N.M.C (2015) in their standards and code of practice, physical barriers such as time restraints or too much paperwork are not a viable excuse. The findings show that nurses appear to be avoiding the necessary conversation around risk and are instead gaining their information from other potentially less reliable sources.

Mental health nursing is recognised as a highly stressful occupation that takes place in an environment that is frequently understaffed, under resourced and unpredictable (Ward 2011). Through her study Ward (2011) identified not only the above but also went on to identify the increase in nursing paperwork as one of the major stressors on the modern-day Mental Health Nurse which in many ways validates the views of the nurses that participated in the study despite the views of the N.M.C (2015). More significantly, Ward (2011) identified that working with patients who are potentially physically threatening as well as demanding is the most stressful part of the mental health nurse role. This finding is further supported by Derkson et al (2011) who identified through their research that working with the behaviours of mental health patients can cause severe emotional stress for the mental health nurse, this can result in feeling of fear and irrationality. When the mental health nurse experiences these emotions then Derkson et al (2011) found the therapeutic relationship is immediately damaged. With this in mind, the concerns of the nurses in this study could be validated when looked at in line with their stressors as mental health nurses. This, however, does not remove from their professional duty to complete the risk assessment documentation alongside the patient.

In identifying that risk assessing could increase the risk of actual or potential threat or distress, along with the obvious factor of more paperwork and documentation to complete, then it would

seem that the nurses in this study could arguably be attempting to reduce their personal stress by avoiding the task of risk assessment despite it being a compulsory part of their role. As a comparable result to this study, Ward (2011) does however go on to identify that the nurses in her study had an unarguable dedication to 'be there' for their patients. The study of 13 female acute mental health nurses whilst limited in the participant variation also identified a commitment to problem solve, advocate and support the patients through what she describes as the 'most difficult part of their lives'. Whilst the arguments of Ward (2011) are valid and are likely to echo the dedication of a large proportion of today's mental health professionals if a larger study were to take place it cannot be ignored that risk assessing is also a core component of nursing as a whole, specifically in the field of mental health.

Professional nurses must endeavour to devote their working time to communicating with patients, their families and carers and not wholly limit their communication to those with other healthcare professionals. In order to enhance healthcare outcomes effective communication is essential (NMC 2015, Buknall et al 2013). There was a fear by the nurses in study two that by having a conversation about risk the therapeutic relationship could be damaged. This is not the case with current literature indicating that in order to build a good therapeutic relationship there must be both sympathetic support and objective assessment of risk. After all a good risk management plan is only as good as the time and effort put into completing it and communicating it findings to others (Bucknell et al 2013).

In order to fully work in today's mental health care system nurses are required to work with the patient rather than do for the patient which requires an awareness of both the lived experience and the emotions involved. If we are to take on board the view that nurses are avoiding risk assessment as evidenced in study one and two, and that this is a defence mechanism rather than other more superficial reasoning, then it is acceptable to reason that nurses' emotions are contributing factors.

The study identifies that the fear is of the threat of actual or potential aggressive behaviour either physically or verbally. Avoidance such as this is a normal human behaviour as a coping mechanism to deal with what is viewed by the individual as a potentially threatening or difficult situation. Michaelson (2011) describes such avoidance as an emotional distancing by the nurse, by doing so the nurse avoids acknowledging the patient's problems whether past or present and the consequence of such is that the nurse is not in the moment with the patient and in turn not

validating their life experiences as a part of their journey. The nurses in study two further attempt to justify this by repeatedly stating that the timing is wrong, that it is the unknown patient that makes them so wary of the potentials from the interaction. This is a factor that is largely agreed with in terms of the therapeutic relationship where the relationship should be built over time. The therapeutic relationship is a helping relationship that is built on trust by both parties it is formulated with an element of faith and of hope that cannot be expected to be there in the first few hours of admission to a psychiatric ward.

Why though does the nurse experience this element of fear that drives to avoidance in completing the documentation around risk. Mental health nurses are highly trained in the art of communication, daily they discuss highly emotive subjects such as suicide and abuse yet the interaction involving discussing all elements of risk around the individual is one which cause discomfort despite the level of expertise. As previously cited Derkson (2011) found that the nurses' emotions of fear and lack of emotional intelligence in such circumstances damages the therapeutic relationship as a standalone issue, therefore whilst the nurses identify the risk assessment documentation as the damaging factor it is likely that it is their approach and apprehensions regarding the potential outcomes that in fact causes the damage.

7.3 Moving Forward.

Recognising that nurses are avoiding the interaction through fear and as a defence mechanism against their personal stressors and including the findings that patients want to be involved in their care it is imperative that the issues around risk assessing be addressed, after all mental health policy sets standards in which patients must be involved in their care. Through this study nursing focus has unarguable shifted from concentrating on the past and 'problem solving' to focussing on the future as determined from the recovery-based approach so heavily embedded in today's nursing practice. This focus on moving forward requires that the nurse and patient work in partnership, that joint objectives are set, and the nurse relinquishes some of their power in order to allow the patient to make decisions around their own care. The concept must also be applied to risk assessing. It is not enough to move only parts of mental health nursing forward with this modern nursing approach and that it must be applied to every aspect of patient care delivered.

Through the studies carried out, it is accepted that risk assessment is difficult in terms of finding a balance between the past and moving forward. The difficult situation of discussing emotive past events and drawing from them the strengths of the individuals in order to allow the individual to build and develop as a person is challenging and appears to be a skill that today's mental health nurses have yet to perfect. It is however imperative that development in this area is progressed to allow for a full patient centred mental health care experience.

8 Discussion

In a recovery focussed mental health service the aim is for patients to be involved in all aspects of their care (Scottish Government, 2012). Within mental health care, risk is incorporated in policy and procedures guiding Mental Health nurses' practice. Earlier studies have shown that while mental health nurses felt strongly in support of risk assessment, many were strongly resistant to patients being involved in completing risk assessments. There is little evidence to suggest why this resistance exists, whether mental health nurses feel risk assessing is detrimental to therapeutic interactions or a barrier to recovery focussed care (Downes et al., 2016). The aim of this project was to explore mental health nurses' attitudes to risk assessment and how that affects recovery focussed care using a mixed methodology research approach. project involving three individual studies to give an overall picture and triangulate evidence to cover the aims of the research. The findings showed that patients are frequently not actively being involved in the risk assessment process with 30% of patients having no risk assessment paperwork completed. Of those completed, 66% indicated that there was no patient involvement in the assessment process, 72% were not completed on time and 83% had not been reviewed since completion. Initial interviews with nursing staff identified that possible reasons for this include lack of time, avoidance of difficult conversations, and a lack of perceived value to the documentation. Interviews with service-users showed a strong wish to be involved in the risk assessment and the care pathway, however the study also indicated that patients had limited awareness that there were risk assessment documents completed regarding their care. The results also showed that patients feel they are not listened to and that they benefit more from their peers on the ward than they do from interactions with nursing staff.

Patient involvement provides a challenge for nurses between providing ethical person-centred care and a need to care for the patient as an expert in the mental health field. When working ethically, the nurse advocates for the patient and argues for patient involvement based on the patient's life experience values and hopes. This allows for joint decision making and encourages hope and offers support. This differs from the medical model used in metal health nursing for many decades which sees decisions made on behalf of the patient, and the expectation that the patient will comply without their involvement in the decision, this is done with the patient's best

interest in mind but takes away any personalisation of the care delivered (Jorgensen et al 2018, Meiklebust et al 2018). Risk assessing without the patient's involvement also raises significant ethical considerations when risk assessments are not agreed and then go on to be shared with others involved in the patient's care (Coffey et al 2017).

Whilst newly qualified nurses may embrace the person-centred care approach, the more experienced nurse may find it more difficult to put in place (Hall et al 2013). The move to recovery focused care is not difficult in the change of the system or the approach but in the challenges, it has to the nurses own personal values and goals and an acceptance of the life choices made by the patient/service user (Hall et al 2013). These personal challenges on nursing practice mean that each nurse may deliver different levels of patient involvement and relate differently to each individual. The lack of consistency in which todays recovery focused nursing model is used relates directly to how each nurse wants to include the patient. The findings of study one showed clearly that patients are not involved in the majority of risk assessments that take place in the selected trust. The findings documented in study two indicate that in the selected NHS trust a culture still exists where nurses choose not to nurture patient's involvement in risk assessment citing possible reasons as time, sensitivity and overload of administrative work taking away from the possibility of patient involvement. Study two highlights that nurses fear confrontation when discussing risk with the patients on the ward, the potential for violence or aggression perceived by the nurses in the study leads to an avoidance of including the patient in the completion of the documentation around risk.

Meiklebust and colleagues (2018) highlight that whilst mental health nurses consider the nurse patient relationship as important in their practice there is conflict with the more medical model which still prevails in today's mental health system despite changes to nursing models. This seems to be an obstacle to recovery focussed care with nurses unable to make the switch despite their values. Meilklehurst et al (2018) found that recovery and person-centred care were similarly not prioritised for nursing documentation due to this lack of consistency.

Lester and colleagues in their study in 2006 record that mental health patients expressed a wish to have greater involvement and more involvement in decision making in their care. They highlight that literature is extremely limited into the discussion around patient involvement despite its prevalence in today's mental health practice, they suggest that this lack of evidence indicates that goals around patient involvement are rarely met. In their study, which involved 45

mental health patients and was based on over 18 focus groups with General Practitioners and patients together, to look at patient involvement in their care in primary mental health they found patients felt undermined by a lack of involvement. Several patients felt that the lack of involvement reflected the negative way in which they were perceived. Interestingly the GPs in Lester and colleagues' study, despite the change in setting and situation, voiced a fear of violence when interacting with the patients in a one-to-one situation a feeling voiced by the nurses in study two of this research.

Undeniably there is a poor recording rate of risk assessment documentation across all audited criteria, however it is difficult to compare this to other NHS trusts, or departments within the same trust, as there appears to be no available research statistics published to provide a comparative comparison of use of the same tool.

With the absence of any formal policy stating that nurses must complete these documents and the inclusion of risk assessing having its basis in guidelines drawn from best practice statements as previously discussed, it is difficult at this stage to draw any hypothesis around the reasoning for non-completion. A study by Maguire et al (2018), which varied slightly in that it specifically looked at acute forensic mental health admission wards, briefly touched on the completion rates of risk assessment. Maguire highlights that given the importance placed on risk assessment in mental health nursing and a requirement that all patients admitted to acute mental health wards have a risk assessment complete, their study found that on 40% of the days the study took place a risk assessment was not carried. Maguire and colleagues could draw no conclusion as to why this was the case drawing a hypothesis that competing demands on nurses, incomplete documentation and staff not valuing the structured risk assessment tools may explain the avoidance. Maguire and colleagues do not specifically look at the reasoning and suggest that further research would be beneficial to identify reasoning.

More concerning may be the low percentage of risk assessments that are completed within the 24-hour guidelines, given the highly emotional arousal of patients on admission to the acute admissions wards it has already been highlighted that this is one of the high-risk time periods for both patients and nursing staff (Lim 2017). Nursing staff by omitting to complete the documentation are placing themselves at an unknown level of risk.

Whilst the first study in the project does not look at the reasoning behind the low completion rates it highlights a failure of mental health nurses within the chosen NHS trust to follow

guidelines for whatever reason. Furthermore, those that were completed showed a low percentage of actual patient involvement, a result which could suggest that similar to the research by Downes (2016) nurses in the Scottish NHS trust selected echo the feelings of their colleagues in Ireland that patients should not be involved in the risk assessment process. To fully understand these findings the two following studies are completed in the hope of identifying a meaning as to why risk assessments are not carried out or wholly completed.

Study two identified that the value of risk assessment as a clinical skill is not disputed by nursing staff, but the structure and timing of its completion is challenging and the value of the documentation itself is questionable. This means that its value as a whole is questioned. The nursing staff interviewed felt strongly that risk assessing was a consistent component of their role, however not one that is rigid in processes to allow for documentation to be valid. Participants felt that risk assessing is more of a fluid process that is often done in the spur of moment, calling on their skills to use solid clinical judgement in a population where patients presentation is ever changing. As shown in the findings, risk assessment paperwork as a clinical tool is not valued. It is also largely avoided as a means of avoiding difficult conversations and as a protective measure to the nurse themselves. This practice however is flawed in that a prevalent part of today's mental health nursing is engaging the patient in such conversations, building an understanding of the patient's journey that has led to admission and planning for the recovery and future of the patient in question. All the risk assessment process should always be done with the involvement of the patient.

There is evidence to support the completion of risk assessment at key points in the patient's journey, more specifically identified as on admission, changes to mental state and prior to discharge (Morgan 1998, Wilson 1996, Morgan 1997). These conclusions were reached over a decade ago when perhaps risk was not as prevalent in the public eye and those with mental health problems were not integrated into society as they are today. It could be that the conclusions were reached in a period when counteracting the argument that risk assessment is a bureaucratic tool used to avoid liability in risky situations was not as relevant.

The resource implications and value of nursing documentation is a regularly debated subject amongst academics and researchers alike. Arguments exist wholly around the amount of time nursing staff need to dedicate to paperwork and the purpose of this effort e.g., to evidence good practice, to improve care, or facilitate outcomes. In mental health nursing the amount of

paperwork requiring completion is greater than other disciplines yet there is little know as to the value of the written care planning documentation in mental health nursing (Drummond et al 2017). Nursing documentations are all legal documents that if the need arose could be used in a court of law as professional documentation and to which all nurses are liable, they are compliant with national laws and governed by professional guidelines and local policies. They govern the standards expected of record keeping in the care environment (NMC 2015).

Risk assessment and care planning are recognised as a key feature in mental health care delivery on an international level. In the UK however there have been critical reports highlighting the poor quality, completion and indeed the actual relevance of mental health paperwork that requires to be completed (CQC 2009,2015). Simpson et al (2016) also writes critically about the quantity of paperwork that is required in mental health nursing. The paper criticises the increasing bureaucracy and resulting pressure on nursing staff suggesting a dissatisfaction amongst nursing staff and patients that too much time is spent on administrative tasks and not on patient care. These views were echoed throughout this study and it is noted that the amount of paperwork as a concern is heavily documented by key members of today's healthcare organisation however there has been little attempt at correcting the displacement of nursing time (Lang 2016, Kinder 2009).

When looking at the risk assessment process as an act to avoid liability the findings and views of the nursing staff are supported in the work of Flintoff et al (2018). They describe that following the rise in mental health patients being treated in the community and presenting within the public eye through an increase in media reporting, the visibility of risk has increased. This, he argues, led to the introduction of risk assessment tools in mental health as a means of reassuring the public and reducing liability. Barker and Buchanan (2005) further support this argument arguing that the demands of risk assessing, and risk management are constraints placed on mental health nurses. They argue that mental health nurses are employed by organisations to protect the organisation from litigation, doing so by implementing strict rules regarding the following policy and procedures.

The findings of study two are supported by the findings in the work of Flintoff and colleagues (2018) recognising risk assessing as anxiety provoking for the mental health practitioners which he states are feelings dealt with by the ‘dutiful’ completion of administration tasks rather than a valuable contribution to nursing documentation. Despite Flintoff's claims, the Department of

Health is clear on the stipulation that risk assessments should be carried out and the documentation should be completed by someone other than the psychiatrist. This places the responsibility on the mental health nurse due to the structure of today's mental health organisational structure. Morgan (1997) through their discussions and recommendations highlight similarly that a risk assessment should be completed during the decision to admit a patient. This directly counteracts the feeling of the nurses in this study that the initial admission period is not the best time to complete the documentation and participants views that risk assessing on admission is counteractive to their attempts at building a therapeutic relationship. Perhaps the primary and most important finding of study two is the nurse's avoidance of the difficult conversations, which appears to be a protective factor against undue stress and fear of threats of verbal and actual violence. Mental health nurses are not always able to work collaboratively with their patients whilst the patient is in crisis or distressed (Lloyd and Carson 2011). Then nurses fear of risk assessing alongside the patient is also echoed in the works of Deuter and colleagues (2013) who recognise that it is 'anxiety provoking' and Langan (2008) who found that nurses often experience 'fear of personal safety' at the prospect of jointly completing the risk assessment.

In study three motivation to be involved in the interviews was low and patients unofficially tended to voice an opinion of "no-one listens anyway". This alone, although not formally part of the study, gave an indication to the researcher that patients felt their opinions were undervalued or that there was "no point" voicing their opinions. This is an opinion that requires further research and discussion as an independent study. The third study was unable to draw a conclusion on why patients were not involved in care planning, but the results clearly indicated that there was limited involvement.

The most significant finding from study three is that all patients voiced a value and a need to be included in the decisions and direction around their care. It was resoundingly important for the patient group to feel listened to and have the opportunity to talk about their lives. Patients gave a strong message that they want to be seen as a person rather than a patient and feel frustrated that they are often not listened to by the nursing staff, a group which they perceive as powerful in their care journey. By seeing the patient in this light and allowing them to share their journey the nurse can build trust and empower the individual while they develop a therapeutic relationship. In risk assessing, nurses must provide a platform where the patient can tell their

story and share their experiences recalling what are factual events with their own viewpoints and opinions. Rimondi and colleagues (2019) highlighted this also in their study of healthcare providers attitudes to patient empowerment recognising the patient as the expert in their own care and the importance of subjective input to achieve patient safety, develop coping skills and allow for positive risk taking to take place. This is not to say that the nurse cannot challenge these views or question the patient's recollection of events in order to assess and discuss the actual level of risk or distress however the sheer aspect of feeling involved will evolve the interaction therapeutically, working towards a feeling of hope and recovery. Nurses who avoid these difficult conversations also avoid the opportunity for personal development and learning as clinicians gaining knowledge from the patients lived experience (Lloyd and Carson 2011). Oxelmark (2018) highlights that the nurse must surrender some power and engage in these interactions to allow the patient to feel fully involved. She argues that patient involvement in such interactions contributes to the patients feeling of safety rather than the view that it will increase the risk of aggression or distress (Rimandi et al 2019).

The world health organisation recognises involving patients in care as an international priority and recognises it as an important aspect of person-centred care (Oxelmark 2018). The results of this study therefore indicate that there is a need to re-evaluate the current processes around risk assessing and a more user friendly and person-centred approach needs to be adapted to meet both local and national policy as well as achieve the national standards expected of today's mental health care providers.

9 Conclusion

There is evidence that patient involvement in care has positive effects on patients, their recovery and over all care experience (Jorgensen et al 2018, Jorgensen et al 2018) yet no papers were identified that explore the benefits of patient involvement in the risk assessment process specifically. Many papers written on risk assessment briefly claim that by being involved in the process the patient experiences a range of outcomes including feeling listened to (Sweeney et al 2014), developing trust for the nurse (Downes et al 2014) and gaining sympathetic support (Department of Health 2007). Most papers such as the work of Hseoi and colleagues (2015), Deuter and colleagues (2013) and Neech and colleagues (2018) take a more negative approach to the risk assessment process and look at the detriments of risk assessing in more detail than they do the overall benefits with particular attention paid to the difficulties in completing the documentation. There is no identifiable research available which looks specifically at what the mental health patient expects from an inpatient admission or how they view the recovery focused care pathway and with-it patient involvement. There appears to be a professional presumption that patients in today's mental health system want to be involved in the planning of their care despite the findings of Tambuyzer and colleagues that this is not always the case and some patients prefer to hand over all decision making to the nurses who they perceive as professionals. Nursing care is based around patient involvement but the fact that no-one has asked the patient themselves is ironic. This area would therefore benefit from exploration to establish the extent to which patients wish to be involved and any limitations to the involvement they wish to have.

As a suggestion from this study mental health nurses should work on their personal self-awareness in the risk assessing process, stress awareness and communication style. There needs to be a cultural shift around viewing risk assessment as a negative conversation to a recognition of the individual's strengths. Risk assessment should no longer be a tool that is viewed as invaluable and restrictive and should be taken forward as a collaborative tool that embraces all aspects of the individual's experiences as a means of planning future care to allow the individual to move forward.

10 Recommendations

1. With national mental health drivers and policy visions that no longer place acute inpatient care at the centre of services and an ever-growing emphasis on individualised care pathways which are primarily community based there is an identified need to streamline the paperwork that goes with the patient journey. Further studies should be carried out to implement a patient care record that is multi-professional and continuous through both community and inpatient care. The hypothesis is that by introducing such a system the duplication of paperwork would be largely eliminated if inpatient care were so required and the risk assessment tool would become a lifelong fluid document that would hold value.
2. The selected NHS board should consider more robust training around risk assessing and risk management with an emphasis on communicating risk amongst the multi-disciplinary team and utilising risk documentation as a more central piece of work to all aspects of care planning. Risk assessment should be used to recognised strengths rather than weaknesses.
3. More research into the collaboration between nurse and patient in documentation and nursing notes as whole to make nursing documentation person centred and less objective.

11 Appendices

11.1 Appendix 1 Consent Form

Consent Form

IRAS ID: 246993
Centre Number:
Study Number:
Participant Identification Number for this trial:

CONSENT FORM

Title of Project: Risk assessing as a barrier to recovery focussed care
Name of Researcher: Claire Danskin

Please initial box

1. I confirm that I have read the information sheet dated..... (version.....) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected.

☐

3. I understand that relevant sections of my medical notes and data collected during the study, may be looked at by individuals from the research team, where it is relevant. I give permission for these individuals to have access to my records.

☐

4. I understand that the information collected about me will be used to support other research in the future and may be shared anonymously with other researchers.

☐

5. I agree to take part in the above study.

☐

Name of Participant Date
Signature

Name of Person taking consent Date

Signature

11.2 Appendix 2 Invitation Letter

Invitation Letter

Claire Danskin
Graduate School
Abertay University

I am writing to invite you to take part in a postgraduate research project regarding current risk assessment in mental health inpatient wards.
I feel it is important to highlight that this project is not being carried out on behalf of NHS Fife, it is being completed as part of my studies for a Masters by Research degree with Abertay University and as such is an independent study.
Before you decide if you like to take part it is important for you to understand why the project is being carried out and what it will involve. Please take time to read the information sheet attached and feel free to ask any questions if there is anything at all you are unsure about.
If you would be willing to take part please reply via email to [redacted]

Yours Sincerely,

Claire Danskin

11.3 Appendix 3 Staff Information Sheet

Nursing Staff Information Sheet

Project Title: Risk assessing as a barrier to recovery focused care. Purpose of this project
The central aim of this study is to gain an understanding of the views and experiences of nursing staff and patients regarding current risk assessment processes in Mental Health inpatient wards.
Why have I been Chosen
You have been chosen as you are an active clinician, and I am interested in your clinical opinion, reasoning and beliefs regarding risk assessment on an acute psychiatric ward. Participation invites have been sent to all current registered nurses on all three acute wards across NHS Fife.
What happens if I take part?
It is completely voluntary to take part in this research project. If you decide to take part, you will be asked to participate in a short informal interview.
What will I have to do?
You will be required to take part in a face to face interview with myself. The interview will be audio recorded however these will always be anonymised. The interviews will be semi-structured and therefore be informal. You will be reminded of consent and procedures prior to the interview and if at any time you wish to withdraw then you can do this freely.
Confidentiality
This study is taking place as a part of my Masters by Research and is not a clinical study on behalf of NHS Fife
To ensure no identifiable data is used your name will not be used at any point during the interviews. All data collated will be coded securing anonymity. Interview recording will be stored securely and coded so that only the researcher can identify the participant at any stage. Once a typed transcript of the interview has been completed the audio data will be destroyed.
How Will Data be Used?
Interviews will be transcribed by myself and coded to remove identifiable information.
Once coded, data will also be utilized by my supervisors at Abertay University. Anonymised data will be used as a research paper reporting current views and experiences around risk assessment as well as suggestions for development for the risk assessing on acute inpatient wards.
Who has reviewed this study?
This project has undergone full ethical scrutiny and all procedures have been approved by the Head of School of Health and Social Science at Abertay University, Abertay University Ethics Council and NHS Fife Ethics Council.

What if I am unhappy during participation?
You are free to withdraw from this project at any time. During the study itself if you decided that you do not wish to continue then any questions already answered will be disregarded, the interview will be deleted immediately along with any documentation. You do not have to give a reason for withdrawing.

How do I contact the research team?
I can be contacted by email on [redacted]

11.4 Appendix 4 Patient Information Sheet

Patient Information sheet

Project Title: Risk assessing as a barrier to recovery focused care.

Purpose of this project

The central aim of this study is to gain an understanding of the views and experiences of nursing staff and patients regarding current risk assessment processes in Mental Health inpatient wards.

Why have I been Chosen

You have been invited to participate as you are currently an inpatient on the ward, and I am interested in your views and experiences regarding risk assessment on an acute psychiatric ward. Participation invites have been sent to all current inpatients on all three acute wards across NHS Fife.

What happens if I take part?

It is completely voluntary to take part in this research project. If you decide to take part, you will be asked to participate in a short informal interview.

What will I have to do?

You will be required to take part in a face to face interview with myself. The interview will be audio recorded however these will always be anonymised. The interviews will be semi-structured and therefore be informal. You will be reminded of consent and procedures prior to the interview and if at any time you wish to withdraw then you can do this freely.

Confidentiality

This study is taking place as a part of my Masters by Research and is not a clinical study on behalf of NHS Fife

To ensure no identifiable data is used your name will not be used at any point during the interviews. All data collated will be coded securing anonymity. Interview recordings will be stored securely and coded so that only the researcher can identify the participant at any stage. Once a typed transcript of the interview has been completed the audio data will be destroyed.

How Will Data be Used?

Interviews will be transcribed by myself and coded to remove identifiable information.

Once coded, data will also be utilized by my supervisors at Abertay University. Anonymised data will be used as a research paper reporting current views and experiences around risk assessment as well as suggestions for development for the risk assessing on acute inpatient wards.

Who has reviewed this study?

This project has undergone full ethical scrutiny and all procedures have been approved by the Head of School of Health and Social Science at Abertay University, Abertay University Ethics Council and NHS Fife Ethics Council.

What if I am unhappy during participation?

You are free to withdraw from this project at any time. During the study itself if you decided that you do not wish to continue then any questions already answered will be disregarded, the interview will be deleted immediately along with any documentation. You do not have to give a reason for withdrawing.

How do I contact the research team? I can be contacted by email on [redacted]

11.5 Appendix 5 Debrief

Debrief

Claire Danskin
Graduate School
Abertay University

I would like to thank you for participating in the study your input and time has been valuable.
If you have any questions or concerns following the interview today please contact me via email to [redacted] . There are a number of supports available if you feel you need any extra support on the topics discussed today and I would be happy to give you details of any supports available.

As previously mentioned, the information gathered will be used as part of my Masters by Research studies and collated into a final paper. If you would like a copy of this paper once completed, please contact me at the above email address.

Again, thank you for your participation

Yours Sincerely,

Claire Danskin

11.6 Appendix 6 Interview Questions

Set Interview Questions

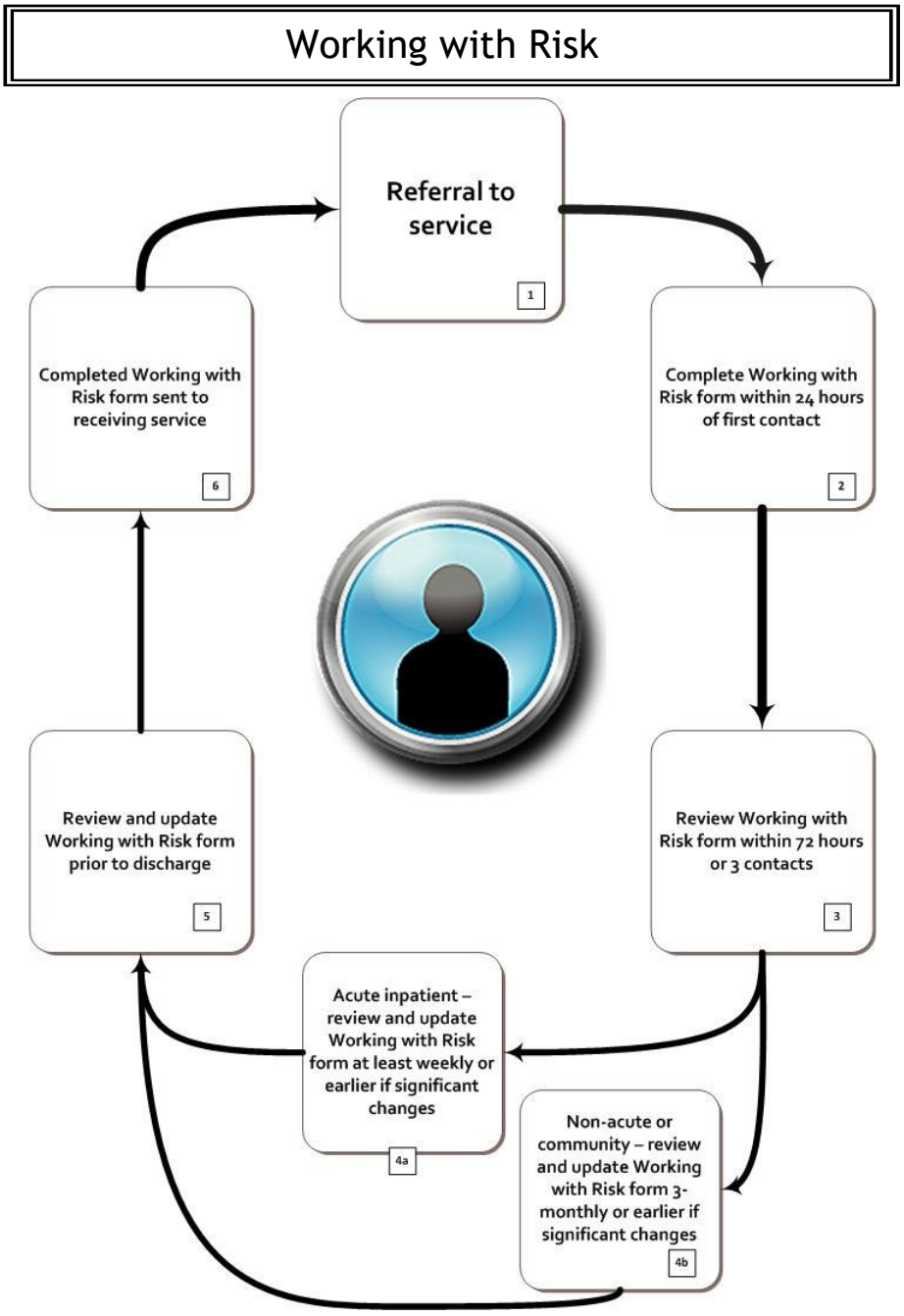
1) can you tell me your understanding of current risk assessing processes with the working with risk tool?

2) How do you feel about the interaction that takes place when completing the initial risk assessment?

3) Who do you feel should be involved in the completion of the documentation?

These will remain consistent through both sets of interviews however due to the sequential analysis that will occur it is expected that further questions will be added as themes become more prominent.

11.7 Appendix 7 Working With Risk



Name	CHI										

	Stage	Description	Completed	Variance Code
1	Referral to a service	The risk assessment process must be commenced on referral of all patient/clients across the Elderly, Learning Disability and Mental Health services to ensure the early identification and management of risks at the first point of contact.	Date: Time: Received by:	
2	Complete Working with Risk form	The Working with Risk form must be completed within **24 hours** of first contact for all patients/clients, in both community and in-patient settings. It is important that all sources of information are explored and shared appropriately.	Date: Time: Received by:	
3	Review Working with Risk form	The Working with Risk form must be reviewed within **72 hours** (in-patient settings) or within **3 contacts** (community settings). Staff should consider how best to communicate and manage identified risks.	Date: Time: Received by:	
4a	Acute inpatient: Review and update Working with Risk	In Acute inpatient settings, the Working with Risk form must be reviewed at least **weekly,** or **earlier** if significant changes occur. Information from the Working with Risk form should be included in Care Plans which should adequately address the risks identified. The multidisciplinary team should review Care Plans and when new risks are identified these should be communicated to all relevant parties as soon as is practicable.	Date: Time: Received by:	
4b	Non-acute or Community: Review and update Working with Risk	In non-acute or community settings the Working with Risk form should be reviewed **3-monthly,** or **earlier** if significant changes occur. Information from the Working with Risk form should be included in Care Plans which should adequately address the risks identified. The multidisciplinary team should review Care Plans and when new risks are identified these should be communicated to all relevant parties as soon as is practicable.	Date: Time: Received by:	
5	Review and update Working with Risk form prior to discharge	The working with Risk form must be reviewed and updated **prior to discharge** from the service, or **on transfer** to any other service. This is crucial in order to ensure receiving services are fully aware of known risks.	Date: Time: Received by:	
6	Send to receiving service	A copy of the most up to date, completed Working with Risk form must be sent to the receiving service and a copy sent to the GP. This must be done **every time** a patient/client moves between services. Staff must decide which, if any, other agencies require a copy of the Working with Risk form (see distribution list).	Date: Time: Received by:	

Name	CHI										

Variance Codes Key

Code	Description
A	Patient discharged before assessment could be fully completed
B	More information required from third party information sources to fully assess risk, e.g. social work notes, family interview, support provider notes
C	Other (please specify)

Name	CHI										

Notes

Working with Risk

Name	CHI										

Risk Indicators

The following are lists of common risk factors to be used to assist in the completion of the *Working with Risk* form and should **not** be used as a checklist.

Risks to Self

- Attempts on their life
- Expressing high levels of distress
- Use of violent methods
- Helplessness or hopelessness
- Misuse of drugs and/or alcohol
- Family history of suicide
- Recent publicity or clusters of suicides
- Major psychiatric diagnoses
- Separated/widowed/divorced
- Expressing suicidal ideas
- Unemployed/retired
- Periods of neglect
- Failing to drink or eat properly
- Considered/planned intent
- Significant life events
- Believe no control over their life
- A sense /feeling of hopelessness
- Difficulty communicating needs
- Denies problems perceived by others
- Unable to shop for self
- Insufficient/inappropriate clothing
- Difficulty managing physical health
- Difficulty maintaining hygiene

Environmental Risks

- Ligature points, e.g. hinges, door handles
- Access to hazardous substances, e.g. cleaning fluid, drugs, alcohol, boiling water
- Access to ignition sources, e.g. lighters, matches, pressured aerosols
- Presence of vulnerable adults
- Presence of children
- Access to objects that could be used as weapons e.g. plant pots, fire extinguishers, unsecured furniture
- Access to weapons, e.g. knives, guns, etc.
- Hazardous escape route for staff
- Presence of drug paraphernalia, e.g. syringes
- Presence of antisocial peers
- Living in inadequate accommodation
- No amenities, e.g. water, gas, electricity
- Living alone (without support)
- Lack of personal supports, e.g. relatives, friends
- Pressure of eviction/repossession

Risks to Others

- Supervision failures, e.g. non-compliance
- Incidents of violence
- Psychosis, e.g. paranoid delusions about others, violent command hallucinations
- Use of weapons – carrying or using
- Misuse of drugs and/or alcohol
- Signs of anger and frustration
- Sexually aggressive behaviour
- Preoccupation with violent fantasy
- Expressing intent to harm others
- Admissions to secure settings
- Dangerous impulsive acts
- Cruelty to animals
- History of employment problems
- Diagnosis of Personality Disorder
- Relationship problems

Risks Associated with Disability

- Sensory impairments
- Intellectual impairments
- Memory/cognitive impairment
- Physical suitability of home
- Mobility inside/outside the home
- Risk of falls
- Risk of wandering
- Risk of accidental injury
- Communication difficulties
- Inappropriate expression of sexuality
- Impulsivity
- Inappropriate demands on services

Physical Medical Risks

- Driving
- Lack of positive social contacts
- Experiencing financial difficulties

Other Risks

- Physical impairments
- Medical conditions
- Self-managing medication
- Monitoring medication side-effects
- Withdrawal from drugs/alcohol
- Self-injury (e.g. cutting, burning)
- Other self-harm (e.g. eating disorder)
- Risks from smoking (e.g. health, fire)
- Manual handling risks
- incontinence

- Exploitation by/of others
- Stated abuse by others (e.g. physical, sexual)
- Abuse of others
- Harassment by/to others (e.g. racial, physical)
- Risk to child(ren)
- Risk to vulnerable others
- Culturally isolated
- Religious or spiritual persecution
- Wilful fire raising
- Risk to staff including threats
- Staff conveying clients in own transport
- Sexually inappropriate behaviour

Working with Risk

Name	CHI										

Name	CHI/Social Work Number
Address	Date of Birth
	Gender
	Post Code
Information sources	

Assessment date	Review date (minimum of 3-monthly or if inpatient at clinical meeting)

Continue overleaf to complete details of any identified risk

Working with Risk

Name	CHI										

‡ WHERE RISK IS UNKNOWN, DETAIL ACTION PLAN INCLUDING REPSONSIBLE PARTIES ‡

REFER TO RISK INDICATORS WHEN COMPLETING

1. Risk from others	**Historical** (over 6 months)	**Current** (in last 6 months)
	Yes/No/Unknown	Yes/No/Unknown
Action plan	**Responsible parties**	

2. Risk to self	**Historical** (over 6 months)	**Current** (in last 6 months)
	Yes/No/Unknown	Yes/No/Unknown
Action plan	**Responsible parties**	

3. Risk to others (Name any specific persons, including staff members)	**Historical** (over 6 months)	**Current** (in last 6 months)
	Yes/No/Unknown	Yes/No/Unknown
Action plan	**Responsible parties**	

Working with Risk

Name	CHI										

4. Risk to children (Name any specific persons, including staff members)	**Historical** (over 6 months)	**Current** (in last 6 months)
	Yes/No/Unknown	Yes/No/Unknown
Action plan	**Responsible parties**	

5. Risk from physical and/or cognitive impairment	**Historical** (over 6 months)	**Current** (in last 6 months)
	Yes/No/Unknown	Yes/No/Unknown
Action plan	**Responsible parties**	

6. Risks associated with engagement with services	**Historical** (over 6 months)	**Current** (in last 6 months)
	Yes/No/Unknown	Yes/No/Unknown
Action plan	**Responsible parties**	

Working with Risk

Name	CHI										

7. Risk from drug and/or alcohol abuse	Historical (over 6 months)	Current (in last 6 months)
	Yes/No/Unknown	Yes/No/Unknown
Action plan	**Responsible parties**	

8. Environmental risk	Historical (over 6 months)	Current (in last 6 months)
	Yes/No/Unknown	Yes/No/Unknown
Action plan	**Responsible parties**	

9. Potential for positive risk taking	Historical (over 6 months)	Current (in last 6 months)
	Yes/No/Unknown	Yes/No/Unknown
Action		

Working with Risk

Name	CHI										

Forensic history			
Client involved?	Yes/No	Carer involved?	Yes/No
Client agreed?	Yes/No	Carer agreed?	Yes/No
If no, please give details			
Discussed/shared with other agencies? (please specify)			

Is there a need for a more detailed assessment?	Yes/No	If YES, detail actions including responsible parties
Actions	Responsible parties	

Where the assessment is not complete	What actions have you taken to ensure completion within the required timescales?
Actions	Responsible parties

Working with Risk

Name	CHI										

Consent has been given to share this information	yes/no

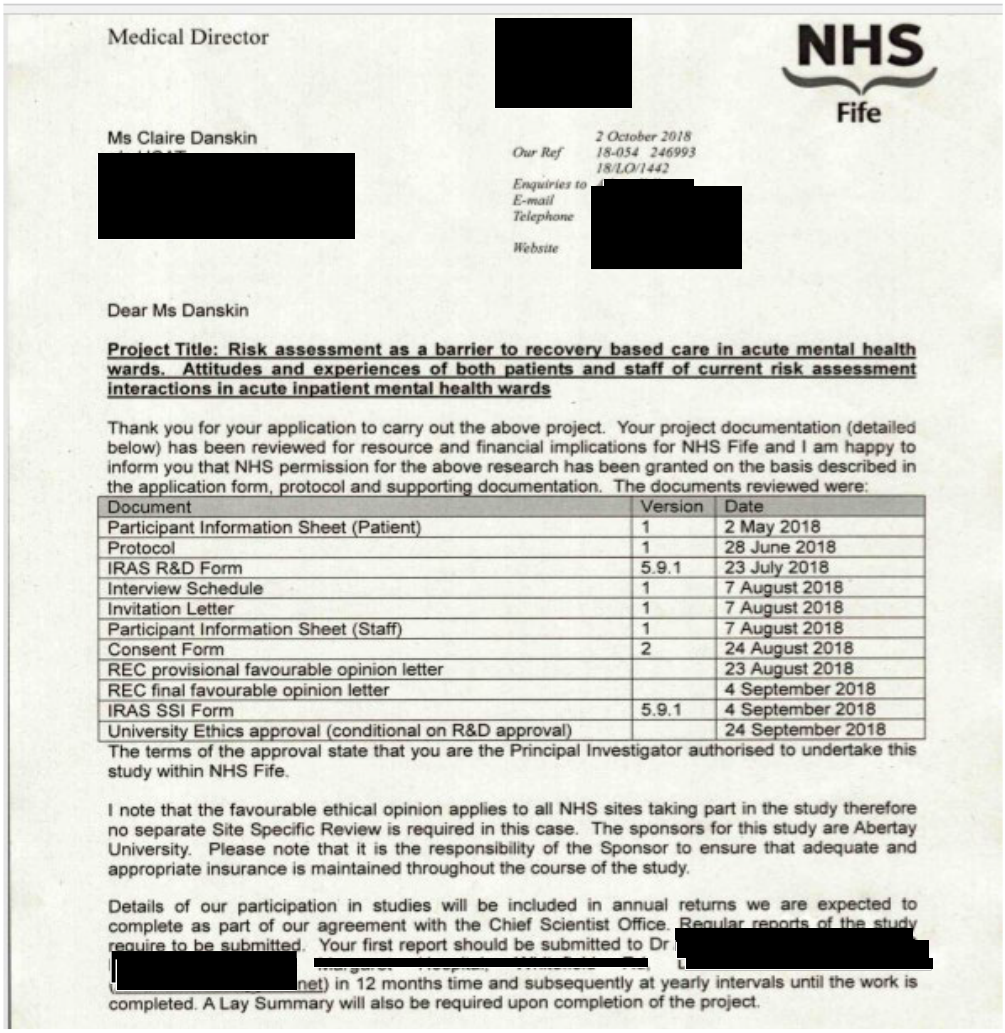
Distribution List (copies sent to, for example):			
GP	yes/no		yes/no
Social Worker	yes/no		yes/no
MHO	yes/no		yes/no
Housing	yes/no		yes/no

Patient:		
Print Name	Signed	Date/Time

Staff			
Print Name	Signed	Designation	Date/Time

11.8 Appendix 8 Ethical Approvals

Ethical Approvals



Medical Director [redacted]

NHS Fife

Ms Claire Danskin
[redacted]

Our Ref 2 October 2018
18-054 246993
18/LO/1442

Enquiries to [redacted]
E-mail
Telephone
Website

Dear Ms Danskin

Project Title: Risk assessment as a barrier to recovery based care in acute mental health wards. Attitudes and experiences of both patients and staff of current risk assessment interactions in acute inpatient mental health wards

Thank you for your application to carry out the above project. Your project documentation (detailed below) has been reviewed for resource and financial implications for NHS Fife and I am happy to inform you that NHS permission for the above research has been granted on the basis described in the application form, protocol and supporting documentation. The documents reviewed were:

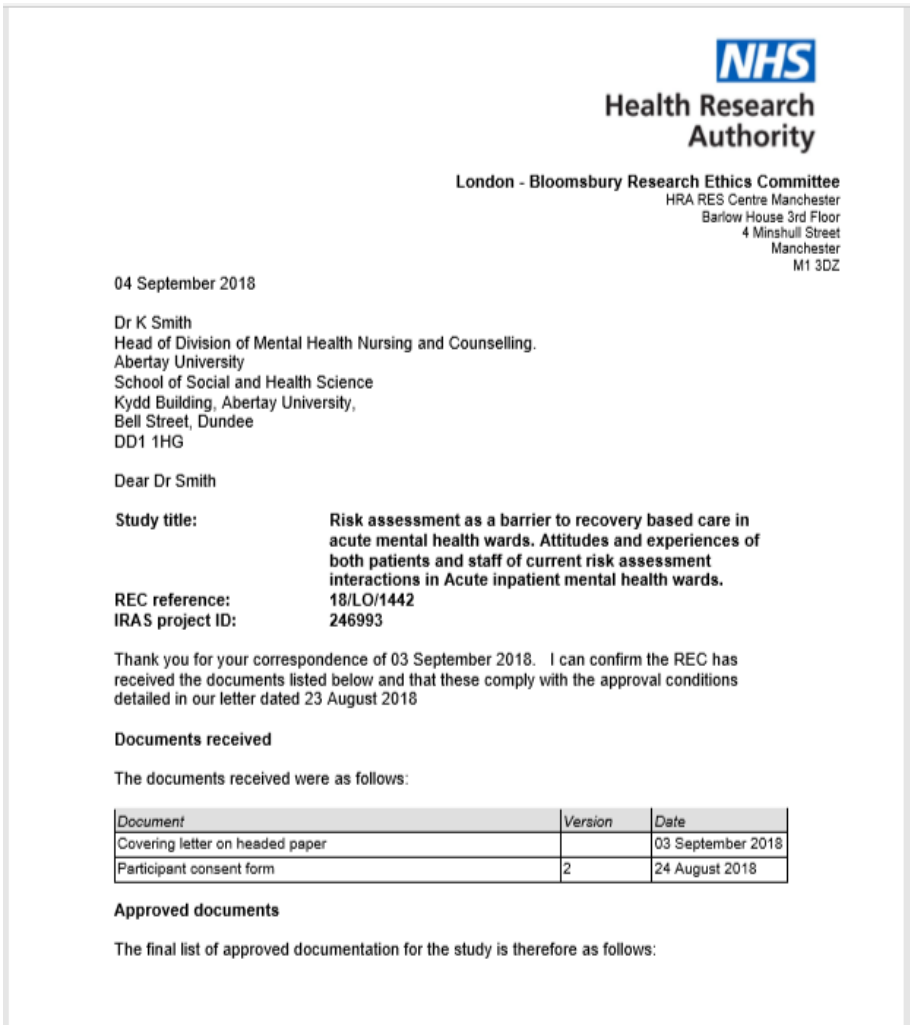
Document	Version	Date
Participant Information Sheet (Patient)	1	2 May 2018
Protocol	1	28 June 2018
IRAS R&D Form	5.9.1	23 July 2018
Interview Schedule	1	7 August 2018
Invitation Letter	1	7 August 2018
Participant Information Sheet (Staff)	1	7 August 2018
Consent Form	2	24 August 2018
REC provisional favourable opinion letter		23 August 2018
REC final favourable opinion letter		4 September 2018
IRAS SSI Form	5.9.1	4 September 2018
University Ethics approval (conditional on R&D approval)		24 September 2018

The terms of the approval state that you are the Principal Investigator authorised to undertake this study within NHS Fife.

I note that the favourable ethical opinion applies to all NHS sites taking part in the study therefore no separate Site Specific Review is required in this case. The sponsors for this study are Abertay University. Please note that it is the responsibility of the Sponsor to ensure that adequate and appropriate insurance is maintained throughout the course of the study.

Details of our participation in studies will be included in annual returns we are expected to complete as part of our agreement with the Chief Scientist Office. Regular reports of the study require to be submitted. Your first report should be submitted to Dr [redacted] net) in 12 months time and subsequently at yearly intervals until the work is completed. A Lay Summary will also be required upon completion of the project.

11.9 Appendix 9 HRA approval



NHS
Health Research Authority

London - Bloomsbury Research Ethics Committee
HRA RES Centre Manchester
Barlow House 3rd Floor
4 Minshull Street
Manchester
M1 3DZ

04 September 2018

Dr K Smith
Head of Division of Mental Health Nursing and Counselling.
Abertay University
School of Social and Health Science
Kydd Building, Abertay University,
Bell Street, Dundee
DD1 1HG

Dear Dr Smith

Study title:	**Risk assessment as a barrier to recovery based care in acute mental health wards. Attitudes and experiences of both patients and staff of current risk assessment interactions in Acute inpatient mental health wards.**
REC reference:	**18/LO/1442**
IRAS project ID:	**246993**

Thank you for your correspondence of 03 September 2018. I can confirm the REC has received the documents listed below and that these comply with the approval conditions detailed in our letter dated 23 August 2018

Documents received

The documents received were as follows:

Document	*Version*	*Date*
Covering letter on headed paper		03 September 2018
Participant consent form	2	24 August 2018

Approved documents

The final list of approved documentation for the study is therefore as follows:

Document	Version	Date
Covering letter on headed paper		03 September 2018
Interview schedules or topic guides for participants [interview schedule]	1	07 August 2018
IRAS Application Form [IRAS_Form_14082018]		14 August 2018
IRAS Checklist XML [Checklist_14082018]		14 August 2018
Letters of invitation to participant [Invitation letters]	1	02 May 2018
Letters of invitation to participant [Invitation Letter]	1	07 August 2018
Participant consent form	2	24 August 2018
Participant information sheet (PIS) [Patient Participant information sheets]	1	02 May 2018
Participant information sheet (PIS) [Staff Participant Information Sheet]	1	07 August 2018
Research protocol or project proposal [Protocol]	1	28 June 2018
Response to Additional Conditions Met		03 September 2018
Summary CV for Chief Investigator (CI) [C.V for K.Smith]	1	02 May 2018
Summary CV for student [Student summary C.V]	1	07 August 2018
Summary CV for supervisor (student research)	1	02 May 2018

You should ensure that the sponsor has a copy of the final documentation for the study. It is the sponsor's responsibility to ensure that the documentation is made available to R&D offices at all participating sites.

18/LO/1442 **Please quote this number on all correspondence**

Yours sincerely

[redacted]

Harriet Wood
REC Assistant

E-mail: nrescommittee.london-bloomsbury@nhs.net
Copy to: *Dr Kate Smith*
[redacted] *NHS Fife R&D department*
Lead Nation - Scotland: nhsg.NRSPCC@nhs.net

12 Bibliography

BAKER, J., SANDERSON, A., CHALLEN, K. and PRICE, O., 2014a. Acute inpatient care in the UK. part 1: recovery-oriented wards. (Report). **17**(10), pp. 18.

BAKER, J., SANDERSON, A., CHALLEN, K. and PRICE, O., 2014b. Acute inpatient care in the UK. part 2: managing risk. (Report). *Mental Health Practice,* **18**(1), pp. 21.

BJORKMAN, T., ANGELMAN, T. and JONSSON, M., 2008. Attitudes towards people with mental illness: a cross-sectional study among nursing staff in psychiatric and somatic care. *Scandinavian Journal of Caring Sciences; S c and.J.Caring Sci.,* vol. 22, no. 2, pp. 170-177.

BOLAND, B. and BREMNER, S., 2013. Squaring the circle: Developing clinical risk management strategies in mental healthcare organisations. *Advances in Psychiatric Treatment,* **19**(2), pp. 153-159.

BORUM, R., FEIN, R., VOSSEKUIL, B. and BERGLUND, J., 1999. Threat assessment: defining an approach for evaluating risk of targeted violence. *Behavioural sciences & the law,* **17**(3), pp. 323-337.

BROWN, P. and CALNAN, M., 2012. *Trusting on the edge: managing uncertainty and vulnerability in the midst of serious mental health problems.* Policy Press.

BROWN, P. and CALNAN, M., 2013. Trust as a Means of Bridging the Management of Risk and the Meeting of Need: A Case Study in Mental Health Service Provision. *Social Policy & Administration,* **47**(3), pp. 242-261.

COFFEY, M., COHEN, R., FAULKNER, A., HANNIGAN, B., SIMPSON, A. and BARLOW, S., 2017. Ordinary risks and accepted fictions: how contrasting and competing priorities work in risk assessment and mental health care planning. *Health Expectations,* **20**(3), pp. 471-483.

COOMBS, T., CROOKES, P. and CURTIS, J., 2013. A comprehensive mental health nursing assessment: variability of content in practice. *Journal of psychiatric and mental health nursing,* **20**(2), pp. 150-155.

CORNELIUS-WHITE, J., MOTSCHNIG-PITRIK, R. and LUX, M., 2013. *Interdisciplinary handbook of the person-centred approach research and theory.* New York: Springer.

CROWE, M. and CARLYLE, D., 2003. Deconstructing risk assessment and management in mental health nursing. *Journal of advanced nursing; J.Adv.Nurs.,* **43**(1), pp. 19-27.

DERKSEN, J., MEIJEL, V.,Berno and DUSSELDORP, V.,Loes, 2011. Emotional intelligence of mental health nurses. *Journal of Clinical Nursing,* **20**(3-4), pp. 555-562.

DEUTER, K., GALLEY, P., CHAMPION, A., GORDON, A., HALCZUK, T., JACKSON, A., JONES, A., LEGG, L., MURISON, J., NEWMAN, C., PROCTER, N. and WILLIAMSON, P., 2013. Risk assessment and risk management: Developing a model of shared learning in clinical practice. *Advances in Mental Health,* **11**(2), pp. 157-162.

DICKENS, G.L., 2015. Re-focusing risk assessment in forensic mental health nursing. *Journal of psychiatric and mental health nursing,* **22**(7), pp. 461-462.

DICKENS, G., PICCIRILLO, M. and ALDERMAN, N., 2013. *Causes and management of aggression and violence in a forensic mental health service: Perspectives of nurses and patients.*

DOWNES, C., GILL, A., DOYLE, L., MORRISSEY, J. and HIGGINS, A., 2016. Survey of mental health nurses' attitudes towards risk assessment, risk assessment tools and positive risk. *Journal of psychiatric and mental health nursing,* **23**(3-4), pp. 188-197.

DRUMMOND, C. and SIMPSON, A., 2017. 'Who's actually gonna read this?' An evaluation of staff experiences of the value of information contained in written care plans in supporting care in three different dementia care settings. *Journal of psychiatric and mental health nursing,* **24**(6), pp. 377.

FLETCHER, R., 2015. CONDUCTING A COMPREHENSIVE MENTAL HEALTH ASSESSMENT: A BIO-PSYCHO-SOCIAL APPROACH. *Journal Of Intellectual Disability Research; J.Intell.Disabil.Res.,* **59**, pp. 25.

FLINTOFF, A., SPEED, E. and MCPHERSON, S., 2018. Risk assessment practice within primary mental health care: A logics perspective. *Health,* , pp. .

FRANKS, R.A., 2005. *Mental Health (Care and Treatment) (Scotland) Act 2003.* Edinburgh: Thomson/W. Green.

GILBERT, E., ADAMS, A. and BUCKINGHAM, C.D., 2011. Examining the relationship between risk assessment and risk management in mental health. *Journal of psychiatric and mental health nursing,* **18**(10), pp. 862-868.

GOMI, S., STARNINO, V. and CANDA, E., 2014. Spiritual Assessment in Mental Health Recovery. *Community mental health journal,* **50**(4), pp. 447-453.

GRANEY, J., HUNT, I.M., QUINLIVAN, L., RODWAY, C., TURNBULL, P., GIANATSI, M., APPLEBY, L. and KAPUR, N., 2020. Suicide risk assessment in UK mental health services: a national mixed-methods study. *The Lancet Psychiatry,* **7**(12), pp. 1046-1053.

HALL, A., WREN, M. and KIRBY, S., 2013. *Care Planning in Mental Health: Promoting Recovery.* Hoboken: Hoboken: John Wiley & Sons, Incorporated.

HAPPELL, B., BENNETTS, W., HARRIS, S., PLATANIA-PHUNG, C., TOHOTOA, J., BYRNE, L. and WYNADEN, D., 2015. Lived experience in teaching mental health nursing: Issues of fear and power. *International Journal of Mental Health Nursing,* **24**(1), pp. 19-27.

HAWLEY, C., GALE, T., SIVAKUMARAN, T. and LITTLECHILD, B., 2010a. Risk assessment in mental health: Staff attitudes and an estimate of time cost. *Journal of Mental Health,* **19**(1), pp. 88.

HAWLEY, C., GALE, T., SIVAKUMARAN, T. and LITTLECHILD, B., 2010b. Risk assessment in mental health: Staff attitudes and an estimate of time cost. *Journal of Mental Health,* **19**(1), pp. 88.

HEPWORTH, I. and MCGOWAN, L., 2013. Do mental health professionals enquire about childhood sexual abuse during routine mental health assessment in acute mental health settings? A substantive literature review. *Journal of psychiatric and mental health nursing,* **20**(6), pp. 473-483.

HEWITT, J.L., 2008. Dangerousness and mental health policy*. Journal of Psychiatric and Mental Health Nursing; J Psychiatr Ment Health Nurs*, vol. 15, no. 3, pp. 186-194 ISSN 1351-0126. DOI 10.1111/j.1365-2850.2007.01188.x.

HIGGINS, A., DOYLE, L., DOWNES, C., MORRISSEY, J., COSTELLO, P., BRENNAN, M. AND NASH, M.,2016. 'There is more to risk and safety planning than dramatic risks: Mental health nurses' risk assessment and safety-management practice', *International journal of mental health nursing; Int J Ment Health Nurs,* 25(2), pp. 159-170.

HIGGINS, A., DOYLE, L., MORRISSEY, J., DOWNES, C., GILL, A. and BAILEY, S., 2016. Documentary analysis of risk-assessment and safety-planning policies and tools in a mental health context. *International Journal of Mental Health Nursing,* **25**(4), pp. 385-395.

HSIAO, C., LU, H. and TSAI, Y., 2015. *Factors influencing mental health nurses' attitudes towards people with mental illness.* Carlton, Vic.] : .

JØRGENSEN, K., RENDTORFF, J.D. and HOLEN, M., 2018. How patient participation is constructed in mental health care: a grounded theory study. *Scandinavian Journal of Caring Sciences,* **32**(4), pp. 1359.

JORGENSEN, K. and RENDTORFF, J.D., 2018. Patient participation in mental health care - perspectives of healthcare professionals: an integrative review. *Scandinavian Journal of Caring Sciences; Scand.J.Caring Sci.,* **32**(2), pp. 490-501.

KINDER, A., 2009. Non-nursing paperwork is an increasing problem. *Nursing Standard,* **23**(28), pp. 33.

LANCET, T., 2011. No mental health without physical health. *The Lancet,* **377**(9766), pp. 611.

LANG, R., 2016. A mountain of paperwork is turning nursing into a desk job. *Nursing Standard,* **30**(29), pp. 33.

LANGAN, J., 2008. Involving mental health service users considered to pose a risk to other people in risk assessment. *Journal of Mental Health,* **17**(5), pp. 471-481.

LEESE D ET AL.,2014. Recovery-focused practice in mental health. *Nursing Times*; 110: 12, 20-22

LESTER, H., TAIT, L., ENGLAND, E. and TRITTER, J., 2006. Patient involvement in primary care mental health: a focus group study. *The British journal of general practice: the journal of the Royal College of General Practitioners,* **56**(527), pp. 415-422.

LIM, E., WYNADEN, D., HESLOP, K., HSIAO, C., LU, H. and TSAI, Y., 2015. Recovery-focussed care: How it can be utilized to reduce aggression in the acute mental health setting; Factors influencing mental health nurses' attitudes towards people with mental illness. *International journal of mental health nursing.,* **26; 24**(5; 3), pp. 445; 27-460; 280.

LLOYD, M. and CARSON, A.M., 2011. Critical conversations: Developing a methodology for service user involvement in mental health nursing. *Nurse education today,* **32**(2),.
MACNEELA, P., SCOTT, A., TREACY, P. and HYDE, A., 2010. In the know: cognitive and social factors in mental health nursing assessment. *Journal of Clinical Nursing,* **19**(9-10), pp. 1298-1306.
MAGUIRE, T., DAFFERN, M., BOWE, S.J. and MCKENNA, B., 2018. Risk assessment and subsequent nursing interventions in a forensic mental health inpatient setting: Associations and impact on aggressive behaviour. *Journal of Clinical Nursing,* **27**(5-6), pp. e971-e983.
MCCLATCHEY, K, MURRAY, J, CHOULIARA, Z, ROWAT, A, HAUGE, SR., 2019. Suicide risk assessment in the emergency department: An investigation of current practice in Scotland. *Int J Clin Pract*.
MYKLEBUST, K.K., 2018. *Nursing documentation in inpatient psychiatry: The relevance of nurse–patient interactions in progress notes—A focus group study with mental health staff.* Oxford, England] : .
NEECH, S.G.B., SCOTT, H., PRIEST, H.M., BRADLEY, E.J. and TWEED, A.E., 2018. Experiences of user involvement in mental health settings: User motivations and benefits. *Journal of psychiatric and mental health nursing,* **25**(5-6), pp. 327-337.
NURSING & MIDWIFERY COUNCIL., 2018. *The code: Professional standards of practice and behaviour for nurses, midwives and nursing associates*. London: Nursing & Midwifery Council.
O' DONOVAN, A., 2007. Patient-centred care in acute psychiatric admission units: reality or rhetoric? *Journal of psychiatric and mental health nursing,* **14**(6), pp. 542-548.
O'Shea, L.,E. *Structured professional judgement approach to risk assessment: generalisability across patient groups for the prediction of adverse outcomes in secure mental health care*.
OXELMARK, L., ULIN, K., CHABOYER, W., BUCKNALL, T. and RINGDAL, M., 2018. Registered Nurses' experiences of patient participation in hospital care: supporting and hindering factors patient participation in care. *Scandinavian Journal of Caring Sciences,* **32**(2), pp. 612-621.
PERKINS, R. and REPPER, J., 2016. Recovery versus risk? From managing risk to the co-production of safety and opportunity. *Mental Health and Social Inclusion,* **20**(2), pp. 101-109.
PERLMAN, D., TAYLOR, E., MOLLOY, L., BRIGHTON, R., PATTERSON, C. and MOXHAM, L., 2018. A Path Analysis of Self-determination and Resiliency for Consumers Living with Mental Illness. *Community mental health journal,* **54**(8), pp. 1239-1244.
ROSE, N., 1998. Governing risky individuals: The role of psychiatry in new regimes of control. *Psychiatry, Psychology and Law,* **5**(2), pp. 177-195.

RIMONDINI, M., BUSCH, I., MAZZI, M., DONISI, V., POLI, A., BOVOLENTA, E. and MORETTI, F., 2019. Patient empowerment in risk management: a mixed-method study to explore mental health professionals' perspective. *BMC Health Services Research,* **19**(1),.
ROSE, N., 1998. Governing risky individuals: The role of psychiatry in new regimes of control. *Psychiatry, Psychology and Law*, vol. 5, no. 2, pp. 177-195 ISSN 1321-8719. DOI 10.1080/13218719809524933.
SWEENEY, A., FAHMY, S., NOLAN, F., MORANT, N., FOX, Z., LLOYD-EVANS, B., OSBORN, D., BURGESS, E., GILBURT, H., MCCABE, R., SLADE, M. and JOHNSON, S., 2014. The Relationship between Therapeutic Alliance and Service User Satisfaction in Mental Health Inpatient Wards and Crisis House Alternatives: A Cross-Sectional Study.(Research Article)(Clinical report). **9**(7),.
SZMUKLER, G., EVERITT, B. and LEESE, M., 2012. Risk assessment and receiver operating characteristic curves. *Psychological medicine; Psychol.Med.,* **42**(5), pp. 895-898.
SZMUKLER, G. and ROSE, N., 2013. Risk Assessment in Mental Health Care: Values and Costs. *Behavioral sciences & the law,* **31**(1), pp. 125-140.
TAMBUYZER, E., PIETERS, G. and VAN AUDENHOVE, C., 2014a. Patient involvement in mental health care: one size does not fit all. *Health Expectations,* **17**(1), pp. 138-150.
TAMBUYZER, E., PIETERS, G. and VAN AUDENHOVE, C., 2014b. Patient involvement in mental health care: one size does not fit all. *Health Expectations,* **17**(1), pp. 138-150.
TUMMEY, R., 2008. Therapeutic skills in nursing: have they been lost?(viewpoint). *Australian Nursing Journal,* **15**(8), pp. 28.
VEDANA, K., MAGRINI, D., ZANETTI, A., MIASSO, A.I., BORGES, T. and DOS SANTOS, M.A., 2017. Attitudes towards suicidal behaviour and associated factors among nursing professionals: A quantitative study. *Journal of psychiatric and mental health nursing; J.Psychiatr.Ment.Health Nurs.,* **24**(9-10), pp. 651-659.
WARD, L., 2011. Mental health nursing and stress: Maintaining balance. *International Journal of Mental Health Nursing,* **20**(2), pp. 77-85.
WONG, L., MORGAN, A., WILKIE, T. and BARBAREE, H., 2012. Quality of Resident Violence Risk Assessments in Psychiatric Emergency Settings. *The Canadian Journal of Psychiatry,* **57**(6), pp. 375-380.
WRIGHT, K.M., DUXBURY, J.A., BAKER, A. and CRUMPTON, A., 2014. A qualitative study into the attitudes of patients and staff towards violence and aggression in a high security hospital. *Journal of psychiatric and mental health nursing,* **21**(2), pp. 184-188